

<i>SERFF Tracking Number:</i>	<i>AMLC-126165883</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Liberty National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42524</i>
<i>Company Tracking Number:</i>	<i>LGSP3A</i>		
<i>TOI:</i>	<i>H151 Individual Health - Hospital/Surgical/Medical Expense</i>	<i>Sub-TOI:</i>	<i>H151.001 Health - Hospital/Surgical/Medical Expense</i>
<i>Product Name:</i>	<i>Limited Benefit Surgical and Medical Expense Policy</i>		
<i>Project Name/Number:</i>	<i>Limited Benefit Surgical and Medical Expense Policy/LGSP3A</i>		

This is not a major medical policy. Policy form LGSP3A is a Limited Benefit Surgical and Medical Expense Policy that is guaranteed renewable which provides surgical and/or medical benefits to the covered person. The policy will be offered as an individual plan as well as a family plan to person's age 0 through 63. This product will be marketed to individuals through licensed agents.

The Actuarial Memorandum and rates for policy form LGSP3A are also enclosed.

I hereby certify that I have carefully reviewed these forms and determined:

1. The forms conform to all insurance statutes and Department requirements of your jurisdiction.
2. The forms contain no provisions previously disapproved by your department.
3. The forms do not contain any unusual or unorthodox provisions and wording.
4. The forms are being filed in Nebraska, our state of domicile, and other jurisdictions in which we are licensed to do business.

Company and Contact

Filing Contact Information

Tom Cao, Compliance Analyst	tcao@torchmarkcorp.com
3700 S. Stonebridge Drive	(214) 544-5389 [Phone]
McKinney, TX 75070	(972) 569-3728[FAX]

Filing Company Information

Liberty National Life Insurance Company	CoCode: 65331	State of Domicile: Nebraska
2001 Third Avenue South	Group Code: 290	Company Type: Life and Health
Birmingham, AL 35233	Group Name: Liberty National Life	State ID Number:
(800) 288-2722 ext. 2912[Phone]	FEIN Number: 63-0124600	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No

SERFF Tracking Number: AMLC-126165883 *State:* Arkansas
Filing Company: Liberty National Life Insurance Company *State Tracking Number:* 42524
Company Tracking Number: LGSP3A
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: Limited Benefit Surgical and Medical Expense Policy
Project Name/Number: Limited Benefit Surgical and Medical Expense Policy/LGSP3A
Fee Explanation: \$50 for policy filing and \$50 for rate filing.
Per Company: No

SERFF Tracking Number: AMLC-126165883 State: Arkansas
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TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$100.00	06/01/2009	28216367

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/05/2009	06/05/2009
Approved-Closed	Rosalind Minor	06/05/2009	06/05/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/03/2009	06/03/2009	Tom Cao	06/04/2009	06/04/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Limited Benefit Surgical and Medical Expense Policy	Form	Tom Cao	06/03/2009	06/03/2009

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Disposition

Disposition Date: 06/05/2009

Implementation Date:

Status: Approved-Closed

Comment:

I re-opened this filing because I forgot to send comments concerning the rates.

Arkansas has had a Departmental procedure for years that rate increases will not be given prior to the first annual anniversary of any policy and after the first annual anniversary date of any policy, increases will not be given more frequently than once in a twelve (12) month period.

We have recently began considering the application of trend increases. We will allow the application of the trend increases as outlined in your actuarial memorandum since you state that no policy will receive a rate increase during its first 12 months in-force, and subsequent rate increases will be separated by at least 6 months.

This is a reminder that if you should require a rate increase based on the experience, that rate increase must be filed for approval and these increases will not be given prior to the first annual anniversary and thereafter, only once in a 12 month period.

Thank you for your cooperation and understanding in this matter.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	Limited Benefit Surgical and Medical Expense Policy	Approved-Closed	Yes
Form	Limited Benefit Surgical and Medical Expense Policy	Replaced	Yes
Form	Limited Benefit Surgical and Medical Expense Policy	Replaced	Yes
Rate	Proposed Annual Premium Rates	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/03/2009
Submitted Date 06/03/2009
Respond By Date
Dear Tom Cao,
This will acknowledge receipt of the captioned filing.

Objection 1
- Limited Benefit Surgical and Medical Expense Policy (Form)
Comment:

Part 8, item 2, of limitations and exclusions, states that you will not pay benefits under this policy for:
Any charges for usual and customary routine nursery care or well-baby care, immunizations, medical examinations or tests of any kind.

Under ACA 23-79-129, benefits are to be covered for routine nursery care and pediatric charges for a well newborn child for up to five full days in a hospital or until the mother is discharged, whichever is the lesser period of time.

Your policy contains benefits for immunizations and well baby care and medical exams and tests as required by ACA 23-79-141. Please reword this exclusion.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/04/2009
Submitted Date 06/04/2009

Dear Rosalind Minor,

SERFF Tracking Number: AMLC-126165883 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42524
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Comments:

This is in response to your recent objection.

Response 1

Comments: Regarding 23-79-129, it states that we need to cover newborn children from the moment of birth which is reflected on page 10 under the section titled Eligibility and Insured's Termination.

Also stated under Part 8 item 2, we added the exclusion "except where specified under Part 7 and all subsections" which should cover the newborn with the same coverage as any other child on this policy.

I did change the policy after noticing an error on item 13 on Part 8.

Related Objection 1

Applies To:

- Limited Benefit Surgical and Medical Expense Policy (Form)

Comment:

Part 8, item 2, of limitations and exclusions, states that you will not pay benefits under this policy for: Any charges for usual and customary routine nursery care or well-baby care, immunizations, medical examinations or tests of any kind.

Under ACA 23-79-129, benefits are to be covered for routine nursery care and pediatric charges for a well newborn child for up to five full days in a hospital or until the mother is discharged, whichever is the lesser period of time.

Your policy contains benefits for immunizations and well baby care and medical exams and tests as required by ACA 23-79-141. Please reword this exclusion.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document
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Data

Limited Benefit Surgical LGSP3A and Medical Expense Policy	Policy/Contract/Fraternal Certificate	Initial	54	LGSP3A - AR.pdf, LG SP3A-AddSchPg s.pdf
Previous Version				
Limited Benefit Surgical LGSP3A and Medical Expense Policy	Policy/Contract/Fraternal Certificate	Initial	54	LGSP3A - AR.pdf, LG SP3A-AddSchPg s.pdf
Limited Benefit Surgical LGSP3A and Medical Expense Policy	Policy/Contract/Fraternal Certificate	Initial	54	LGSP3A - AR.pdf, LG SP3A-AddSchPg s.pdf

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Amendment Letter

Amendment Date:
 Submitted Date: 06/03/2009

Comments:

I apologize, I did not have the correct form number on the pages.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LGSP3A	Policy/Contract/Fraternal Certificate	Limited Surgical and Medical Expense Policy	Initial				54	LGSP3A - AR.pdf LGSP3A-AddSchPgs.pdf

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Form Schedule

Lead Form Number: LGSP3A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	LGSP3A	Policy/Contract	Limited Benefit Surgical and Medical Expense Policy Certificate	Initial		54	LGSP3A - AR.pdf LGSP3A-AddSchPgs.pdf

LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE POLICY
 GUARANTEED RENEWABLE FOR YOU AND EACH COVERED FAMILY MEMBER AS STATED IN THE RENEWAL
 AGREEMENT. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS.

Liberty National Life Insurance Company
 P. O. BOX 8080, MCKINNEY, TEXAS 75070 * (972) 529-5085
 A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

30-DAY RIGHT TO EXAMINE POLICY

If YOU are not satisfied with this policy for any reason, return it to OUR Administrative Offices or to the agent within 30 days after YOU receive it. Any premium YOU paid will be refunded. The policy will be void from the beginning. It will be as if no policy had been issued.

RENEWAL AGREEMENT

YOU can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under OUR applicable table of premium rates that is in effect on the respective due dates of the premiums. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54] PART 2 Radiation Therapy Benefit up to \$ [5,000.00] PART 3 Ambulance Benefit up to \$ [200.00]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]} PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
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POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	12345678	09-01-08	10-01-08	\$100.00]

ADDITIONAL BENEFIT RIDERS

[Increasing Benefit Rider], [Critical Illness Benefit Rider], [Accident Benefit Rider], [Cancer Benefit Rider]

The Policy Schedule includes premiums for additional benefit riders, if any, unless provided to the contrary in the rider(s).

INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. For the purpose of determining benefits payable for a particular SICKNESS of a COVERED PERSON after the applicable benefit limits for that SICKNESS have been paid by the COMPANY, it shall be considered a new SICKNESS, which is then again covered under this policy, if the COVERED PERSON goes without a PHYSICIAN'S advice or treatment for that particular SICKNESS for a period of 24 consecutive months. OUR obligation to make payment under this policy for any particular SICKNESS or INJURY shall not exceed the amounts disclosed in the Benefit Schedule or described elsewhere in this policy. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a charge that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. An expense or charge is incurred on the date the care, treatment, service, or supply is provided.

PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by YOU or a covered FAMILY MEMBER during the 12 months immediately after the effective date of this policy if that loss results from a PRE-EXISTING CONDITION. In addition, any PRE-EXISTING CONDITION listed on the application is not covered for the first 12 months after the policy effective date. Conditions, illnesses, diseases, disorders, or injuries specifically excluded by rider are never covered.

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DEFINITIONS

Where used in this policy:

ACCIDENT and **ACCIDENTAL** means that which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual and unforeseen.

AMBULATORY SURGICAL CENTER means a freestanding facility, other than a PHYSICIAN'S office, where surgical and diagnostic services are provided on an ambulatory basis.

CHILD PREVENTIVE HEALTH CARE SERVICES means PHYSICIAN-delivered or PHYSICIAN-supervised services for covered dependents from birth through eighteen (18) years of age that are provided for PERIODIC PREVENTIVE CARE VISITS, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

COVERED PERSON means YOU or any covered Family Member.

DIABETES SELF-MANAGEMENT TRAINING means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Such instruction is provided in accordance with a program in compliance with the National Standards for DIABETES SELF-MANAGEMENT EDUCATION PROGRAM as developed by the American Diabetes Association.

FAMILY MEMBER means a person who is named in the application for coverage under this policy, other than the Proposed Insured, or a person who has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

HOSPITAL means a medical facility, operated pursuant to law, which: (1) is primarily and continuously engaged in providing medical and diagnostic care for the treatment of sick or injured persons on an acute care inpatient basis under the supervision of one or more licensed PHYSICIANS for which a charge is made; and (2) provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.). "HOSPITAL" does not mean a facility or special unit of a facility primarily operated as: (a) a convalescent, skilled nursing, swing bed, or other nursing facility; (b) a facility or special unit of a facility primarily affording rehabilitative care; or (c) a facility or special unit of a facility primarily affording care or treatment for the aged, or for chemical dependency, alcohol abuse, or mental or nervous disorder.

HOSPITAL STAY means one day or more of inpatient confinement within a HOSPITAL, and under the care of a PHYSICIAN, for which a charge for room and board is incurred due to an INJURY or SICKNESS.

INHERITED METABOLIC DISEASE means a disease caused by an inherited abnormality of body chemistry.

INJURY means accidental bodily INJURY sustained by a COVERED PERSON which is the direct cause independently of disease, bodily infirmity or other cause of the loss and occurs while the insurance is in force.

INTENSIVE CARE means care which is provided within a separate area or unit of a HOSPITAL that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of PHYSICIANS, nurses or other medical specialists assisting in the unit. INTENSIVE CARE does not include: step-down, isolation, telemetry, or post-intensive care units of a HOSPITAL.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a PHYSICIAN for the dietary treatment of an INHERITED METABOLIC DISEASE.

MASTECTOMY means the removal of all or part of the breast for MEDICALLY NECESSARY reasons as determined by a PHYSICIAN who is licensed as a medical doctor or doctor of osteopathy.

MEDICALLY NECESSARY means:

- 1) consistent with the symptoms or diagnosis and treatment of YOUR or a covered FAMILY MEMBER'S SICKNESS or INJURY; and
- 2) appropriate with regard to the standards of good medical practice; and
- 3) the most appropriate level of service that can be safely provided to YOU or a covered FAMILY MEMBER.

In order to determine that care is MEDICALLY NECESSARY, WE reserve the right to obtain, at Our expense, a second opinion from a PHYSICIAN who (a) is not an employee or owner of a facility or agency from which YOU or a covered FAMILY MEMBER receive care, and (b) specializes in the condition that is the subject of YOUR claim.

MENTAL ILLNESS means psychosis, neurosis or an emotional disorder.

PERIODIC PREVENTIVE CARE VISITS means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

PHYSICIAN and **DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorders, or diagnostic services, which are specifically covered under PART 7 of this policy, PHYSICIAN or DOCTOR does not include YOU or any member of YOUR household or immediate family. Primary Care Physician means a PHYSICIAN who provides basic diagnosis and treatment of common illnesses and medical conditions. A Specialist means a PHYSICIAN who provides diagnosis and treatment for a specific specialty of medicine for which he or she has received additional education, training and experience.

PRE-EXISTING CONDITION means any medical condition, illness, disease, disorder, or INJURY for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy. It also means any medical condition, illness, disease, disorder, or INJURY for which YOU or the covered FAMILY MEMBER did receive treatment or medical advice during the 12 month period immediately prior to YOUR or the covered FAMILY MEMBER'S effective date of coverage under this policy. PRE-EXISTING CONDITION will include any medical condition, illness, disease, disorder, or INJURY listed on YOUR application for YOU or a covered FAMILY MEMBER, which occurred within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy, irrespective of whether a rider has been issued. It also means a pregnancy existing at any time prior to, and which continues to exist as of, the Effective Date of YOUR or the covered FAMILY MEMBER'S coverage under this policy.

RADIATION THERAPY means the treatment of a SICKNESS by application of roentgen rays, radium, ultraviolet, and other radiations.

RELATIVE VALUE UNITS means the total unit value of the service, including all three components: PHYSICIAN work, facility practice expense, and professional liability expense, as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS).

RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) means the scale of relative values for medical and SURGICAL PROCEDURES that is maintained and updated by the Centers for Medicare and Medicaid Services with input from the AMA/Specialty Society Relative Value Scale Committee (RUC).

SICKNESS means a medical condition, illness, disease, or disorder which first manifests itself more than 30 days after the Effective Date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder. SICKNESS includes continuations and reoccurrences of the medical condition, illness, disease, or disorder, and all general conditions associated with, related to, or caused by the medical condition, illness, disease, or disorder.

SURGICAL PROCEDURE means the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, endoscopic examinations, and any one procedure designated by Current Procedural Terminology codes as surgery, except that venipuncture for the collection of blood for the purpose of performing a test shall not be considered a surgery. SURGICAL PROCEDURE shall also include all post-operative care for the 90-day period following surgery.

WE, US, OUR and **COMPANY** mean Liberty National Life Insurance Company.

YOU, YOUR, YOURS and **INSURED** mean the COVERED PERSON whose name is shown in the POLICY SCHEDULE as the Insured.

PART 1

SURGICAL PROCEDURE BENEFITS

1. SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN performing a MEDICALLY NECESSARY SURGICAL PROCEDURE on YOU or a covered FAMILY MEMBER. Such SURGICAL PROCEDURE and expenses incurred must be the result of an INJURY or SICKNESS. The benefit will be equal to the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE, but, in no event will the benefit payable be more than the lesser of either: (a) an amount equal to the Surgery Conversion Factor stated in the Benefit Schedule times the RELATIVE VALUE UNITS for that procedure as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) last published and effective before the date of the SURGICAL PROCEDURE; or (b) the Surgeon Benefit Limit amount stated in the Benefit Schedule. If the SURGICAL PROCEDURE is not contained in the RBRVS, the benefit payable will be the lesser of: (a) the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE; (b) the amount that would be payable for the most comparable SURGICAL PROCEDURE in severity and gravity; or (c) the Surgeon Benefit Limit amount stated in the Benefit Schedule. In the event that the RBRVS is discontinued, WE shall thereafter have the right to continue to use the RELATIVE VALUE UNITS contained in the last published RBRVS or, at OUR option and upon reasonable written notice to YOU, WE may designate an alternative, generally accepted, method to be used for determining relative values from the date specified in OUR notice.

WE will not pay a benefit for more than one SURGICAL PROCEDURE (the largest applicable) under this PART 1 for all SURGICAL PROCEDURES performed as a result of any one INJURY or SICKNESS.

For any one INJURY or SICKNESS, WE will pay the greater of either: (a) the Surgeon Benefit provided in this PART 1; or (b) the total of all Doctor Office Visit Benefits under PART 4 which would otherwise be payable.

2. ASSISTANT SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY assistance to the primary PHYSICIAN during a Surgical Procedure for which a Surgeon Benefit is payable under this PART 1. Such surgical assistance and expenses incurred must be the result of an INJURY or SICKNESS. The benefits will not exceed 20% of the amount payable for the Surgeon Benefit.

3. ADMINISTRATION OF ANESTHETIC BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY administration of anesthetic to YOU or a covered FAMILY MEMBER during a SURGICAL PROCEDURE for which a Surgeon Benefit is payable under this PART 1. Such anesthetic administration and expenses incurred must be the result of an INJURY or SICKNESS. The administration of anesthetic must be by a PHYSICIAN or a legally qualified anesthetist. The benefits will not exceed 25% of the amount payable for the Surgeon Benefit. WE will not pay any benefit for the administration of anesthetic by the primary PHYSICIAN or the assistant surgeon.

PART 2 RADIATION THERAPY BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY RADIATION THERAPY provided to or for YOU or a covered FAMILY MEMBER at a HOSPITAL or PHYSICIAN'S office. Such RADIATION THERAPY and expenses incurred must be the result of an INJURY or SICKNESS. WE will not pay benefits in excess of the Radiation Therapy Benefit stated in the Benefit Schedule for all such expense incurred because of any one INJURY or SICKNESS. The benefit under this PART 2 will be calculated and paid based on a single diagnosed SICKNESS, may be present or has or have been treated.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 2, only one benefit, the largest, will be payable for such expense.

PART 3 AMBULANCE BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY ambulance service for YOU or a covered FAMILY MEMBER. Such ambulance service and expenses incurred must be the result of an INJURY or SICKNESS. The ambulance service must be to or from a HOSPITAL. WE will not pay more than the Ambulance Benefit stated in the Benefit Schedule for any one INJURY or SICKNESS, regardless of the frequency that ambulance service is required because of that INJURY or SICKNESS. Only one benefit will be payable for any one trip.

{PART 4 DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER for outpatient care, treatment and services, by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one Doctor Office Visit Benefit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER and regardless of the number of visits during the day;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.}

PART 5

OUTPATIENT EXPENSE BENEFIT

WE will pay a benefit at the rate of 80% of expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Outpatient Deductible Amount stated in the Benefit Schedule, for MEDICALLY NECESSARY outpatient care, treatment, and services provided to or for YOU or a covered FAMILY MEMBER. Such outpatient care, treatment, and services and expenses incurred must be the result of an INJURY or SICKNESS. outpatient care, treatment, and services include:

1. Outpatient Hospital expense;
2. Diagnostic imaging performed at other duly licensed locations; and
3. Laboratory tests performed at other duly licensed locations, including pathology tests.

WE will not pay in excess of the Outpatient Expense Benefit stated in the Benefit Schedule for expenses incurred for outpatient care, treatment, and services resulting from any one INJURY or SICKNESS.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 5, only one benefit, the largest, will be payable for such expense.

PART 6

REFUND OF PREMIUMS FOR LOSS OF LIFE FROM ACCIDENTAL INJURY

WE will refund to YOUR estate the premiums paid for YOUR individual coverage under this policy if YOU die due to an INJURY while YOUR coverage is in force or effect. WE will refund to YOU the premiums paid under this policy for the coverage of a covered FAMILY MEMBER if that member dies due to an INJURY while his or her coverage is in force or effect.

To be entitled to said refund of premium, the death must occur while this policy is in force and within 180 days of the INJURY causing death.

PART 7

OTHER BENEFITS

On the condition that a benefit for expenses incurred for the following care, treatment, services, and supplies is not elsewhere provided in this policy, WE will pay benefits for expenses incurred for the following care, treatment, services, and supplies provided to a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 7 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 7 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, DEDUCTIBLES, CO-PAYS, CO-INSURANCE, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 7. A benefit payable under this PART 7 shall not duplicate any benefit or benefits payable under any other PART or PARTS of this policy. The total benefit payable for care, treatment, services, and supplies covered under this PART 7 of the policy, together with benefits paid under any other policy or policies issued by US to YOU or a covered FAMILY MEMBER, will never exceed the total expense incurred by YOU or the covered FAMILY MEMBER for such care, treatment, services, and supplies.

1. MATERNITY BENEFITS, MINIMUM HOSPITAL STAYS

As described in PART 8(1), this policy does not provide benefits for normal pregnancy. However, for a HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will provide a benefit for expenses incurred due to a distinct complication of pregnancy by any COVERED PERSON for a HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor.

2. PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY BENEFIT

WE will provide a benefit for the following expenses incurred by YOU or a covered FAMILY MEMBER for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

- 1) Reconstruction of the breast on which MEDICALLY NECESSARY MASTECTOMY has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) Prosthesis and physical complications from all stages of MASTECTOMY, including lymphedemas.

To be covered, breast reconstructive surgery must be in the manner chosen by the affected COVERED PERSON'S treating PHYSICIAN, who is a licensed medical doctor or doctor of osteopathy, consistent with prevailing medical standards, and in consultation with the affected COVERED PERSON.

A benefit for prosthetic devices and breast reconstructive surgery covered under this subpart of PART 7 will be paid as follows:

- a. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy because such care is not being provided in relation to a SICKNESS, or because maximum policy benefits have been paid previously for the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY, WE will consider that COVERED PERSON'S prosthetic devices and breast reconstructive surgery as though they were for a new Sickness (separate from the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY) under this policy.
- b. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$500 for prosthetic devices and breast reconstructive surgery for any one COVERED PERSON.

3. CHILD PREVENTIVE HEALTH CARE SERVICES BENEFIT

WE will provide a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for a periodic review related to CHILD HEALTH SUPERVISION SERVICES for a COVERED PERSON when that COVERED PERSON attains the following ages: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. CHILD HEALTH SUPERVISION SERVICES shall be limited to services provided by or under the supervision of a single PHYSICIAN or other primary health care provider who is a licensed medical doctor or doctor of osteopathy during the course of one visit.

If the periodic visit is not otherwise covered under another PART of this policy, WE will pay a benefit under this subpart of PART 7 in accordance with the following:

- a. For the expenses incurred for the services attributable to a history, physical examination, developmental assessment anticipatory guidance, or any combination thereof, WE will make payment as if such services were for a covered PHYSICIAN'S wellness exam payable under PART 4(3). This benefit will be provided for each such periodic visit. The combined amount of payments made during any policy year for any one COVERED PERSON under 16 years of age for Doctor Office Visits payable under PART 4, as stated in the Benefit Schedule, and for periodic visits during which services attributable to a history, physical examination, developmental assessment and anticipatory guidance are provided, payable as set forth herein, shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule.
- b. For the expenses incurred for the services attributable to laboratory tests, WE will pay a sum of money equal to 80% of the incurred expenses, not to exceed a maximum benefit of \$250 for each covered periodic visit during which, laboratory tests are provided to or for any one COVERED PERSON.
- c. For the expense incurred for covered immunizations for a COVERED PERSON under this subpart of PART 7, WE will pay a sum of money equal to 100% of the incurred expense.

Benefits paid under this subpart of PART 7 shall not exceed the reimbursement levels established by the Insurance Commissioner that shall not exceed those established for the same services under the Medicaid program in the State of Arkansas. This benefit is exempt from any deductible provision, but remains subject to all co-pay and coinsurance provisions, of this policy except in regards to immunizations the benefit for which is not subject to any deductible, copayment, or coinsurance provisions of this policy.

4. DIABETES BENEFIT

WE will provide a benefit for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

The diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Any nutrition counseling must be provided by a licensed dietician.

For equipment, supplies, treatment, service, training, or any combination thereof, for diabetes covered under this subpart of PART 7, and not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge not to exceed a maximum benefit of \$1,500 during any policy year for all equipment, supplies, treatment, service, or training for diabetes provided that COVERED PERSON.

5. ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES BENEFIT

WE will provide a benefit for general anesthesia, hospital charges, or both for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

- 1) is younger than 7 years of age;
- 2) has a serious mental or physical condition; or
- 3) has significant behavioral problems.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 7.

A benefit for anesthesia or facility charges for dental care covered under this subpart of PART 7 will be paid as follows:

- a. For anesthesia or facility charges for dental care not otherwise eligible for coverage under this policy, WE will consider that COVERED PERSON'S incurred expenses for anesthesia and facility charges for dental care as though they were eligible for coverage under and PART 5 of the policy.
- b. For anesthesia or facility charges for dental care not covered under PARTS 1-5 of this policy, or brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$100 for all anesthesia and facility charges for dental care provided to any one COVERED PERSON.

6. SPEECH AND HEARING DISORDERS BENEFIT

WE will provide a benefit for the expenses incurred for MEDICALLY NECESSARY care and treatment of loss or impairment of speech or hearing, or both if treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association or both, and which fall within the scope of their license or certification. This benefit does not cover hearing aids, instruments or devices.

Benefits for speech and hearing disorders covered under this subpart of PART 7 will be paid as follows:

- a. For speech or hearing treatment or care not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered SICKNESS, WE will consider that COVERED PERSON'S speech or hearing treatment as though it was for a covered SICKNESS under PART 4. The combined amount of payments made for any one COVERED PERSON for Physician Office Visit Benefits payable under PART 4 and speech and hearing disorders benefits payable under this subpart of PART 7 shall not exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for all benefits paid during any one policy year.
- b. For speech or hearing treatment not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each visit with a professional described in this subpart for any one COVERED PERSON, and when combined with the Physician Office Visit Benefits payable under PART 4, not to exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for benefits paid during any one policy year.

7. MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT

WE will provide a benefit for the expense incurred for Medical Foods, Low Protein Modified Food Products, amino acid modified preparations and any other special dietary products and formulas for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products, amino acid modified preparations and other special dietary products and formulas are prescribed as **MEDICALLY NECESSARY** for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a **PHYSICIAN**.

For benefits for Medical Foods and Low Protein Modified Food Products covered under this subpart of PART 7 that are not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$2,400 for each Covered Person during any one policy year as provided under the Income Tax Act of 1929.

8. COLORECTAL CANCER SCREENING BENEFIT

WE will provide a benefit for the expense incurred for colorectal cancer examinations and laboratory tests for a **COVERED PERSON** who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a **PHYSICIAN** licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
 - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
 - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
 - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and
 - iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Benefits for colorectal cancer screening covered under this subpart of PART 7 will be paid as follows:

- a. For colorectal cancer screening not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered **SICKNESS**, WE will consider that **COVERED PERSON'S** colorectal cancer testing as though it was for a covered **SICKNESS** under PART 4 and PART 5 of this policy.
- b. For colorectal cancer screening not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each screening provided a **COVERED PERSON**.

9. MENTAL ILLNESS BENEFIT

WE will provide a benefit for expenses incurred for a **COVERED PERSON** for the treatment of **MENTAL ILLNESS** on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

10. TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER BENEFIT

WE will provide coverage for the treatment and care provided to or for a **COVERED PERSON** for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is **MEDICALLY NECESSARY** to treat conditions caused by a congenital or developmental deformity, disease, disorder, or **INJURY**. A temporomandibular and craniomandibular disorder shall be treated as any other **SICKNESS** under this policy, and benefits will be paid under PARTS 1-5 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.

PART 8

LIMITATIONS AND EXCLUSIONS

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, WE will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, PHYSICIAN-prescribed rest, morning SICKNESS, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of INJURY or SICKNESS (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a HOSPITAL; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by INJURY), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any inpatient or outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies for which YOU or a covered FAMILY MEMBER do not incur a charge; or
6. Any outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies that are not MEDICALLY NECESSARY for diagnosis of or for care, treatment, or services resulting from an INJURY or SICKNESS; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during an inpatient HOSPITAL STAY; or
10. Any rehabilitative care services received at a facility not meeting the definition of a HOSPITAL; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the COVERED PERSON has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a PHYSICIAN; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any COVERED PERSON being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

POLICY PROVISIONS

ELIGIBILITY AND INSURED'S TERMINATION: YOU, as the Insured, are the beneficiary of YOUR covered FAMILY MEMBERS. Every transaction relating to this policy shall be between US and YOU.

A new family member (including husband, wife, or any children under the age of 19 at the time the policy is issued) will be covered; each new member must be named in the application. Stepchildren and legally adopted children can be included if listed in the application. Any newborn or newly adopted children of the PRIMARY INSURED will automatically be a COVERED PERSON from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children YOU have filed a petition to adopt. YOU may apply for coverage on other dependents acquired after the EFFECTIVE DATE of the policy, subject to OUR approval.

Coverage on YOUR children terminate when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on YOU due to a physical or mental handicap, or because they are a full-time student under age 23. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 21st birthday, then the child will continue to be a COVERED PERSON for as long as such disability continues. Proof of such incapacity or disability must be furnished upon OUR request, but not more often than annually.

In the event of YOUR death or other termination of YOUR coverage, the following shall successively become the Insured: (1) YOUR spouse (if YOUR spouse is a covered FAMILY MEMBER), or (2) YOUR eldest remaining covered FAMILY MEMBER.

RIGHTS OF A SPOUSE: Should YOU and YOUR spouse dissolve YOUR marriage by a valid decree of dissolution of marriage and the spouse was a covered FAMILY MEMBER, the spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, the spouse must make application to the COMPANY within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting or probationary period is required, except to the extent that such period has not been met under the prior policy.

PREMIUM PAYMENT: This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time of the place where YOU reside, and remains in effect until the same hour on the date that the initial term expires.

The effective date of this policy, the first premium, and the date the initial term expires are stated in the POLICY SCHEDULE. All premiums, except the first premium, shall be due and payable at OUR Administrative Offices.

ENTIRE CONTRACT; CHANGES: This policy, with the application and attached papers, is the entire contract between YOU and US. No change in this policy shall be effective until approved by an officer of US. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the effective date, only fraudulent misstatements in the application may be used to void this policy or deny any claim for loss incurred after the 2-year period.

After 2 years from the date of an endorsement adding a FAMILY MEMBER, other than a newborn or newly adopted child, only fraudulent misstatements in the application may be used to void the endorsement or deny any claim for loss incurred after the 2 year period.

GRACE PERIOD: This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, this policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by US without requiring an application for reinstatement will reinstate this policy.

If WE require an application, this policy will be reinstated when WE approve the application, or on the 45th day after WE receive it, unless WE have previously written to YOU of its disapproval.

The reinstated policy will cover only loss that results from an INJURY sustained after the date of reinstatement or a SICKNESS that manifests itself more than 10 days after such date. In all other respects, YOUR rights and OUR rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given to US within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to US at OUR Administrative Offices in McKinney, Texas or to OUR agent.

Notice should include YOUR name and YOUR policy number.

CLAIM FORMS: When WE receive the Notice of Claim, WE will send YOU forms for filing proof of loss. If these forms are not given to YOU within 15 days, YOU may meet the proof of loss requirements by giving US a written statement of the nature and extent of the loss within the time limit stated in the PROOFS OF LOSS Provision set forth below.

PROOFS OF LOSS: YOU must give US written proof of loss to OUR satisfaction within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, WE will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless YOU were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: After receiving proper written proof of loss satisfactory to US, WE will pay to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person rendering services covered by this policy, all benefits then due for such loss.

PAYMENT OF CLAIMS: Benefits will be paid, after receiving a claim form and proper written proof of loss satisfactory to US, to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person providing care, treatment, services, or supplies covered by this policy. Any benefit unpaid at death may be paid to YOUR named beneficiary or, at OUR option, to YOUR estate. If benefits are payable to YOUR estate, WE can pay benefits up to \$3,000 to someone related to YOU by blood or marriage whom WE consider to be entitled to the benefits. WE will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS: WE, at OUR expense, have the right to have YOU or a covered FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

NONDUPLICATION OF COVERAGE: The benefits payable under this policy shall be excess over benefits paid or payable or required to be provided:

1. under any workers' compensation, occupational disease, employers' liability or similar law;
2. under any motor vehicle no-fault plan or coverage or similar law; and
3. under any national, state, or other governmental plan not limited to governmental employees or their families, such as Medicare or Medicaid.

REFUND OF UNEARNED PREMIUMS ON DEATH: Upon the death of a FAMILY MEMBER insured under this policy, WE will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after WE receive proof of death.

SUBROGATION; REIMBURSEMENT: YOU agree that, to the extent of the benefits paid under this policy, WE shall be subrogated to all YOUR rights to damages or recovery for any INJURY or SICKNESS, or any care, treatment, services, or supplies provided, for which a third party or parties, or their insurance carrier(s), are or may be liable or responsible. YOU agree to repay US first out of any monies YOU receive or recover by settlement, judgment or otherwise, regardless of whether YOU are fully compensated for YOUR losses and damages. In the event that WE retain OUR own attorney to represent OUR subrogation interest, WE will not be responsible for paying a portion of YOUR attorney fees or costs.

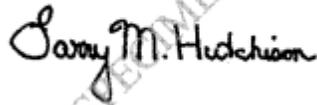
YOU assign to US YOUR claims and rights against all liable or responsible third party or parties and their insurance carrier(s) to the extent of OUR payments, and shall do nothing after the loss to prejudice OUR subrogation rights. Entering into a settlement or compromise arrangement with a third party or parties, or their insurance carrier(s), without OUR prior written consent, shall be deemed to prejudice OUR subrogation rights. YOU shall promptly advise US in writing whenever a claim or demand against a third party or parties, or their insurance carrier(s), is made, and shall further provide to US such additional information and execute and deliver such instruments or papers as are reasonably requested by US to secure OUR subrogation rights. YOU agree to fully cooperate in protecting OUR subrogation rights against the liable or responsible third party or parties, and their insurance carrier(s).

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of the claim is required to be given.

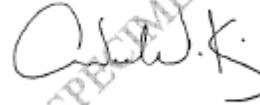
CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which YOU reside on that date, is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under this policy shall be binding upon US unless the original written assignment (or a copy thereof) is on file at OUR Administrative Offices. At OUR option, WE may waive this requirement. WE do not assume any responsibility for the validity of any assignment.

This policy is signed for US by OUR President and Secretary.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Visit Copay (Primary Care Physician) . \$ [35.00]} {Doctor Visit Copay (Specialist). \$ [35.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4

DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a Surgical Procedure, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not to exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care PHYSICIAN or Specialist.] }

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit up to \$ [200.00]} {Wellness Exam Benefit up to \$ [200.00]} {Doctor Visit Copay (Primary Care Physician) .\$ [35.00]} {Doctor Visit Copay (Specialist). \$ [50.00]} {Doctor Office Visit Yearly Maximum. [6] Visits}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit 80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4

DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a Hospital (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require Surgical Procedure, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule, Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit as the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, BUT, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total number of DOCTOR visits for which benefits are payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care Physician or Specialist.] }

Doctor Visit Copay w/Visit Max.

SERFF Tracking Number: AMLC-126165883 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42524
 Company Tracking Number: LGSP3A
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense
 Product Name: Limited Benefit Surgical and Medical Expense Policy
 Project Name/Number: Limited Benefit Surgical and Medical Expense Policy/LGSP3A

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	Proposed Annual Premium Rates	LGSP3A	New		LNL LSGP3A Rate Page - AR.pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY

McKinney, Texas

Policy Form LGSP3A

Limited Benefit Surgical and Medical Expense Policy

NEW PRODUCT FILING

ARKANSAS

Proposed Annual Premium Rates

Benefit Description	Issue Age	Base Rates		Rates with R-LIB25		Rates with R-LIB50	
		Male	Female	Male	Female	Male	Female
Surgical Procedure Benefits Maximum Benefit: \$3,000 for Surgeon \$600 for Ass't Surgeon \$750 for Anesthetist	CHILD (00-17)	87.45	87.45	98.89	98.89	105.49	105.49
	18-25	100.21	112.53	112.09	129.80	118.25	138.82
	26-30	108.13	161.70	121.99	184.14	129.47	196.02
	31-35	126.39	202.29	146.08	231.00	157.63	247.50
	36-40	169.84	244.53	198.55	281.49	215.71	303.16
	41-45	230.23	288.86	268.62	333.41	292.71	361.57
	46-50	283.14	326.92	329.78	379.17	358.93	411.73
	51-55	335.61	371.58	387.42	427.57	417.67	460.02
	56-60	388.41	411.73	437.69	462.88	456.39	482.13
	61-63	420.09	429.55	449.46	472.01	464.97	487.85
Outpatient Expense Benefit \$0 Deductible \$250 Maximum Benefit	CHILD (00-17)	201.08	201.08	226.93	226.93	241.56	241.56
	18-25	183.48	294.58	205.26	330.00	216.26	348.37
	26-30	199.10	332.20	221.43	373.34	232.76	394.24
	31-35	204.49	376.20	229.35	423.83	243.32	450.45
	36-40	215.38	408.43	244.42	462.99	260.81	493.90
	41-45	228.69	427.46	260.81	486.53	280.50	522.28
	46-50	238.81	431.64	274.01	492.36	295.24	528.88
	51-55	252.12	431.86	287.98	492.47	308.44	528.88
	56-60	270.05	431.97	303.27	492.47	315.70	528.88
	61-63	285.01	432.30	309.10	492.47	319.33	528.88
Doctor Office Visit Benefit Maximum \$25 per visit; \$50 Wellness Exam Benefit per Policy Year; \$250 Maximum Benefit per Policy Year	CHILD (00-17)	191.07	191.07	191.07	191.07	191.07	191.07
	18-25	102.41	223.85	102.41	223.85	102.41	223.85
	26-30	116.05	231.66	116.05	231.66	116.05	231.66
	31-35	125.51	235.07	125.51	235.07	125.51	235.07
	36-40	133.43	237.27	133.43	237.27	133.43	237.27
	41-45	139.48	237.93	139.48	237.93	139.48	237.93
	46-50	142.56	237.93	142.56	237.93	142.56	237.93
	51-55	146.96	237.93	146.96	237.93	146.96	237.93
	56-60	154.22	237.93	154.22	237.93	154.22	237.93
	61-63	159.17	237.93	159.17	237.93	159.17	237.93
Radiation Therapy Benefit \$5,000 Maximum Benefit	CHILD (00-17)	1.54	1.54	1.54	1.54	1.54	1.54
	18-25	2.42	2.42	2.42	2.42	2.42	2.42
	26-30	3.30	3.30	3.30	3.30	3.30	3.30
	31-35	4.07	4.18	4.07	4.18	4.07	4.18
	36-40	5.06	5.39	5.06	5.39	5.06	5.39
	41-45	6.49	8.36	6.49	8.36	6.49	8.36
	46-50	9.46	12.32	9.46	12.32	9.46	12.32
	51-55	16.06	17.93	16.06	17.93	16.06	17.93
	56-60	24.86	24.42	24.86	24.42	24.86	24.42
	61-63	29.70	25.52	29.70	25.52	29.70	25.52
Other Miscellaneous Benefits Ambulance Benefit - \$200 Refund of Premium upon Accidental Death	CHILD (00-17)	2.64	2.64	2.64	2.64	2.64	2.64
	18-25	2.64	2.31	2.64	2.31	2.64	2.31
	26-30	2.75	2.53	2.75	2.53	2.75	2.53
	31-35	2.97	2.53	2.97	2.53	2.97	2.53
	36-40	3.52	2.75	3.52	2.75	3.52	2.75
	41-45	4.07	3.41	4.07	3.41	4.07	3.41
	46-50	4.73	4.07	4.73	4.07	4.73	4.07
	51-55	5.28	4.95	5.28	4.95	5.28	4.95
	56-60	6.60	5.83	6.60	5.83	6.60	5.83
	61-63	7.81	5.94	7.81	5.94	7.81	5.94

These rates will be discounted 10% when husband and wife are covered under the same policy

Modal Premium Factors:

Annual	1.000
Semiannual	0.520
Quarterly	0.265
Monthly	1/11

Modal Premium = (Annual Premium) x (Modal Premium Factor)

LIBERTY NATIONAL LIFE INSURANCE COMPANY

McKinney, Texas

Policy Form LGSP3A

Limited Benefit Surgical and Medical Expense Policy

NEW PRODUCT FILING

ARKANSAS

Proposed Annual Premium Rates

Benefit Description	Issue Age	Base Rates		Rates with R-LIB25		Rates with R-LIB50	
		Male	Female	Male	Female	Male	Female
	CHILD (00-17)	59.95	59.95	59.95	59.95	59.95	59.95
Mandated Benefits	18-25	2.97	1.98	2.97	1.98	2.97	1.98
	26-30	2.97	1.98	2.97	1.98	2.97	1.98
	31-35	2.97	1.98	2.97	1.98	2.97	1.98
	36-40	3.08	1.98	3.08	1.98	3.08	1.98
	41-45	3.08	4.07	3.08	4.07	3.08	4.07
	46-50	3.08	4.07	3.08	4.07	3.08	4.07
	51-55	3.08	4.07	3.08	4.07	3.08	4.07
	56-60	3.08	3.96	3.08	3.96	3.08	3.96
	61-63	3.08	3.96	3.08	3.96	3.08	3.96

These rates will be discounted 10% when husband and wife are covered under the same policy

Modal Premium Factors:

Annual	1.000
Semiannual	0.520
Quarterly	0.265
Monthly	1/11

Modal Premium = (Annual Premium) x (Modal Premium Factor)

SERFF Tracking Number: AMLC-126165883 State: Arkansas
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42524
Company Tracking Number: LGSP3A
TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense
Product Name: Limited Benefit Surgical and Medical Expense Policy
Project Name/Number: Limited Benefit Surgical and Medical Expense Policy/LGSP3A

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/05/2009
Comments:
Attachment:
LGSP3A - Readability Certification.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 06/05/2009
Comments:
Attachment:
LUNIV(03).pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 06/05/2009
Comments:
Attachment:
DS-LGSP3A(03).pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY
McKinney, Texas

READABILITY CERTIFICATION

We hereby certify we have carefully reviewed the form(s) listed below and to the best of our knowledge and ability determine the Flesch scale analysis readability test score to be as shown:

<u>FORM</u>	<u>SCORE</u>
LGSP3A - LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE	54

Date: May 27, 2009



Michael J. Gaisbauer, Vice President

FORM S-1351

Requested Effective Date (mm-dd-yyyy)

- - 20

Payment Mode Monthly Semi-Annual
 Quarterly Annual

Payment Type Bank Draft Direct Bill

Draft Day (01 to 28 only)

[BASE POLICY]

Proposed Insured Spouse Child 1 Child 2 Child 3 Child 4 Child 5 Child 6 Child 7 Child 8

IF YOU FAIL TO CHOOSE A DEDUCTIBLE OR MAXIMUM BENEFIT AMOUNT, IT WILL AUTOMATICALLY DEFAULT TO LOWEST AMOUNT.

LIBERTY INDEPENDENCE FREEDOM

DAILY HOSPITAL ROOM AND BOARD BENEFIT		[OPTION 1]		[OPTION 2]		[OPTION 3]		[OPTION 4]	
[N/A]	[N/A]	<input type="radio"/> \$100 <input type="radio"/> \$200	<input type="radio"/> \$300 <input type="radio"/> \$400	<input type="radio"/> \$100 <input type="radio"/> \$200	<input type="radio"/> \$300 <input type="radio"/> \$400	<input type="radio"/> \$400 <input type="radio"/> \$500	<input type="radio"/> \$600 <input type="radio"/> \$700	<input type="radio"/> \$600 <input type="radio"/> \$700 <input type="radio"/> \$800	<input type="radio"/> \$900 <input type="radio"/> \$1,000
MISCELLANEOUS HOSPITAL EXPENSE BENEFIT		Deductible	Maximum	Choose Deductible	Choose Maximum	Choose Deductible	Choose Maximum	Choose Deductible	Choose Maximum
[N/A]	[N/A]	\$250	\$2,500	<input type="radio"/> \$ 500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,500	<input type="radio"/> \$ 7,500 <input type="radio"/> \$15,000	<input type="radio"/> \$ 500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,500	<input type="radio"/> \$15,000 <input type="radio"/> \$25,000	<input type="radio"/> \$ 500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,500 <input type="radio"/> \$5,000	<input type="radio"/> \$25,000 <input type="radio"/> \$35,000 <input type="radio"/> \$50,000 <small>(Only with \$50,000 Max)</small>
SURGICAL PROCEDURE BENEFIT MAXIMUM		<input type="radio"/> \$700 <input type="radio"/> \$1,400	[\$3,000]	[\$1,500]	<input type="radio"/> \$3,000 <input type="radio"/> \$5,000	<input type="radio"/> \$5,000 <input type="radio"/> \$7,500	<input type="radio"/> \$7,500 <input type="radio"/> \$10,000		
OUTPATIENT EXPENSE BENEFIT		[\$50]	[\$250]	[\$50]	<input type="radio"/> \$250 <input type="radio"/> \$500	<input type="radio"/> \$500 <input type="radio"/> \$750 <input type="radio"/> \$1,000	<input type="radio"/> \$1,000 <input type="radio"/> \$1,250 <input type="radio"/> \$1,500		
DOCTOR OFFICE VISIT BENEFIT (Per Visit)		[N/A]	[\$25 (\$250 Annual Max)]	[\$25 (\$250 Annual Max)]	<input type="radio"/> \$25 (\$250 Annual Max) <input type="radio"/> \$50 (\$500 Annual Max)	<input type="radio"/> \$50 (\$500 Annual Max) <input type="radio"/> \$75 (\$750 Annual Max) <input type="radio"/> \$35 Copay (\$500 Annual Max)	<input type="radio"/> \$75 (\$750 Annual Max) <input type="radio"/> \$35 Copay (\$500 Annual Max) <input type="radio"/> \$35 Copay (\$1,000 Annual Max)		

Premium \$, .

Additional Premium Required

OPTIONAL RIDERS

CANCER BENEFIT

Proposed Insured Spouse Child 1 Child 2 Child 3 Child 4 Child 5 Child 6 Child 7 Child 8

\$10,000 \$20,000 \$30,000 \$50,000

Premium \$, .

CRITICAL ILLNESS BENEFIT

Proposed Insured Spouse

\$10,000 \$20,000 \$30,000 \$50,000

Premium \$, .

ACCIDENT BENEFIT

Proposed Insured Spouse Child 1 Child 2 Child 3 Child 4 Child 5 Child 6 Child 7 Child 8

\$10,000 \$20,000 \$30,000

Premium \$, .

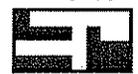
INCREASING BENEFIT

Proposed Insured Spouse Child 1 Child 2 Child 3 Child 4 Child 5 Child 6 Child 7 Child 8

WITH LIBERTY BASE POLICY R-LIB25 R-LIB50

WITH FREEDOM BASE POLICY R-LIB25 R-LIB50

Premium \$, .



Child 2	First Name <input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	Height (ft. in.) <input type="text"/> <input type="text"/> Weight (lbs.) <input type="text"/> <input type="text"/>
	Last Name <input type="text"/>			
	Age <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/> - <input type="text"/> - <input type="text"/>	I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No	

Child 3	First Name <input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	Height (ft. in.) <input type="text"/> <input type="text"/> Weight (lbs.) <input type="text"/> <input type="text"/>
	Last Name <input type="text"/>			
	Age <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/> - <input type="text"/> - <input type="text"/>	I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No	

	PROPOSED INSURED	SPOUSE	CHILD 1	CHILD 2	CHILD 3
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1. During the past 90 days, except for minor illness of less than one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or any Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age?	<input type="radio"/>				
2. Has the Proposed Insured or any Family Member EVER been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antibodies for the AIDS (HIV) virus?	<input type="radio"/>				
3. Has the Proposed Insured or any Family Member EVER had:					
a. Any disease or disorder of the heart or circulatory system including but not limited to heart attack or stroke; high blood pressure?	<input type="radio"/>				
b. Any disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?	<input type="radio"/>				
c. Any disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver or connective tissue; Lupus, collagen disease, pancreas, pituitary or adrenal gland?	<input type="radio"/>				
d. Any disease or disorder of the brain (including but not limited to retardation, dementia or Alzheimer's), mental or nervous system (including but not limited to seizures or convulsions), back or spine; paralysis or arthritis?	<input type="radio"/>				
e. Any cancer, tumor, cyst, hernia, goiter, diabetes, blood disorders including but not limited to anemia or spleen disorder?	<input type="radio"/>				
f. Any internal or skin cancer, melanoma, malignant growth, leukemia, Hodgkins disease or premalignant lesions?	<input type="radio"/>				
4. During the past three (3) years, has the Proposed Insured or any Family Member:					
a. Had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?	<input type="radio"/>				
b. Received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?	<input type="radio"/>				
c. Used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?	<input type="radio"/>				
5. Does the Proposed Insured or any Family Member participate in any hazardous sports or avocations? No benefits will be provided for loss due to such participation.	<input type="radio"/>				
6. During the past five (5) years, has the Proposed Insured or any Family Member:					
a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s) or surgery that has not yet been performed, or is awaiting medical test results?	<input type="radio"/>				
b. Been confined in a hospital?	<input type="radio"/>				
7. During the past two (2) years, has the Proposed Insured or any Family Member:					
a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?	<input type="radio"/>				
b. Been hospitalized 3 or more times?	<input type="radio"/>				
c. Received any disability benefits?	<input type="radio"/>				



- 8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance?
If "YES" list coverage type _____
- 9. Does the Proposed Insured or any Family Member intend to replace or change any existing health insurance? If "YES" a replacement notice must be completed and signed.
- 10. Have you received an outline of coverage?

PROPOSED INSURED	SPOUSE	CHILD 1	CHILD 2	CHILD 3
YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
<input type="radio"/> <input type="radio"/>				
<input type="radio"/> <input type="radio"/>				
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			

If Optional Life coverage is chosen, please answer questions 11 thru 13:

- 11. Has the Proposed Insured or Spouse used tobacco in any form within the past 12 months?
- 12. Does the Proposed Insured or Spouse have any existing life insurance policies or annuity contracts?
- 13. Will the life insurance being applied for replace or change any existing life insurance policies or annuity contracts? If "YES" a replacement notice must be completed and signed.

<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

If the Proposed Insured or any Family Member answered "Yes" to any of questions 1 -7, provide details below for each "Yes" answer.

* In column below list "P" for Proposed Insured, "S" for Spouse, "C1" for Child 1, "C2" for Child 2 and "C3" for Child 3.

*	Dates	Illness/Injury	Operation?	Name/Address/Telephone of Doctors & Hospitals	Complete Recovery?

AGREEMENT: I hereby apply to Liberty National Life Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to Liberty National Life Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]. Information for consumers about MIB may be obtained on its website at www.mib.com.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To the best of your knowledge as soliciting agent, is the insurance applied for intended to replace any existing life, annuity or health insurance policies or contracts? Yes No

If "YES" a replacement notice must be completed and signed.

Date Application Signed (mm-dd-yyyy) - -

State

Signed

Agent's Signature

Last Name Agent No.

Print First 5 Letters of Agent's Last Name

Signed

Applicant (Proposed Insured)

Signed _____

Applicant (If other than the Proposed Insured)

SEND POLICY TO: Agent Insured (The Policy will be sent to Insured unless otherwise instructed.)

LIBERTY NATIONAL LIFE INSURANCE COMPANY
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

OUTLINE OF COVERAGE - POLICY FORM LGSP3A
Retain This Form For Your Records.
LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE COVERAGE

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of the policy for which You, as the proposed insured designated in the application, are applying. This outline of coverage is not the insurance contract and does not alter or modify the terms of the policy. The policy itself will set forth, in detail, the rights and obligations of the parties if Your application is accepted. It is, therefore, important that You **READ YOUR POLICY CAREFULLY** when it is delivered to You!

Limited Benefit Surgical and Medical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for certain hospital and surgical expenses incurred as a result of a covered Injury or Sickness as defined in the policy. Coverage is provided for Hospital outpatient services, surgical services, anesthesia services, and other medical services, subject to any limitations, exclusions, deductibles, co-insurance and co-payment requirements set forth in the policy. Benefits provided under this policy are limited, and coverage is not provided for all Hospital, surgical or medical expenses.

BENEFITS - Eligible Surgical and Medical Expenses. Benefits listed below are subject to the applicable deductibles, coinsurance and copays, and benefit amounts shown in Your policy Benefit Schedule.

- 1. Surgical Procedure Benefits, up to [\$3,000.00]**
Benefits are payable for one Medically Necessary Surgical Procedure due to a covered Injury or Sickness. Benefits are payable for expenses incurred up to the lesser of the Surgery Conversion Factor stated in the Benefit Schedule multiplied by the Relative Value Units for such procedure or the Surgeon Benefit Limit. The policy pays up to 20% of the Surgeon Benefit for one Assistant Surgeon and up to 25% of the Surgeon Benefit for one anesthesiologist.
- 2. Radiation Therapy Benefit, up to [\$5,000.00]**
A benefit is payable for expenses incurred by a Covered Person for Medically Necessary Radiation Therapy treatment provided for any one covered Injury or Sickness at a Hospital or Doctor's office, up to the Radiation Therapy Benefit.
- 3. Ambulance Benefit, up to [\$200.00]**
A benefit is payable for expenses incurred by a Covered Person for Medically Necessary ambulance service to or from a Hospital due to a covered Injury or Sickness, not to exceed [\$200.00]. Only one benefit will be payable for any one Injury or Sickness.
- 4. Doctor Office Visit Benefit [\$25.00] Per Visit [\$250.00] Annual Maximum**
Benefits are payable at the rate of 80% of expenses incurred up to the Doctor Office Visit Benefit for Medically Necessary outpatient treatment by a Doctor at the Doctor's office, clinic, Hospital (on an outpatient basis), or Your residence due to a covered Injury or Sickness. For any one Injury or Sickness requiring a Surgical Procedure, We will pay only one benefit, the greater of the Surgeon Benefit or the total of the Doctor Office Visit Benefit otherwise payable.
- 5. Outpatient Expense Benefit, up to [\$250.00]**
We will pay a benefit at the rate of 80% of expenses incurred by a Covered Person (in excess of the Outpatient Deductible Amount stated in the Benefit Schedule) for Medically Necessary outpatient services and treatment including outpatient Hospital expense, diagnostic imaging and laboratory tests, due to a covered Injury or Sickness. We will not pay more than the Outpatient Expense Benefit shown in the Benefit Schedule for all such expenses incurred in relation to any one Injury or Sickness.
- 6. Refund of Premiums for Loss of Life from Accidental Injury** - We will refund the premiums paid for Your individual coverage under this policy if You die due to an Injury while Your coverage is in force or effect. We will refund to You the premiums paid under this policy for the coverage of a covered Family Member if that member dies due to an Injury while their coverage is in force or effect. Death must occur within 180 days of the Injury.
- 7. Optional Riders** – Available with the LGSP3A are a Cancer Rider, a Critical Illness Rider and an Accident Rider.

YOUR POLICY MAY CONTAIN OTHER BENEFITS MANDATED BY YOUR STATE. REFER TO PART 7 OF YOUR POLICY.

PRE-EXISTING CONDITION LIMITATION

Any medical condition, illness, disease, disorder, or injury for which a Covered Person received treatment or medical advice, or for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, within the 12 - month period prior to the policy effective date will not be covered for the first 12 months following the policy effective date. A pregnancy existing at any time prior to, and which continues to exist as of, the Effective Date of such Covered Person's coverage under the policy, or any medical condition, illness, disease, disorder, or injury listed on Your application which occurred within the 12 month period prior to the policy effective date, will not be covered for the first 12 months following the policy effective date.

LIMITATIONS AND EXCLUSIONS

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, We will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, Physician-prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a Hospital; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by Injury), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any Hospital Stay, Intensive Care unit admission, or other care, treatment, services, or supplies for which You or a covered Family Member do not incur a charge; or
6. Any Hospital Stay, Intensive Care unit admission, or other care, treatment, services, or supplies that are not Medically Necessary for diagnosis of or for care, treatment, or services resulting from an Injury or Sickness; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during a Hospital Stay; or
10. Any rehabilitative care or services received at a facility not meeting the definition of a Hospital; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any Infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the Covered Person has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any Covered Person being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

TERMINATION OF COVERAGE FOR CHILDREN

Coverage on YOUR children terminate when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on YOU due to a physical or mental handicap, or because they are a full-time student under age 23. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 21st birthday, then the child will continue to be a COVERED PERSON for as long as such disability continues. Proof of such incapacity or disability must be furnished upon OUR request, but not more often than annually.

RENEWAL AGREEMENT

You can continue the policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of the premiums. We have the right to change the renewal premiums for the policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. We also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

A grace period of 31 days will be granted for the payment of each renewal premium. The policy will stay in force during the grace period.

PREMIUM

Your premium for the policy is monthly \$ _____, quarterly \$ _____, semi-annually \$ _____, or annually \$ _____ . You pay a one time policy fee of \$ _____ .

SERFF Tracking Number: AMLC-126165883 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42524
 Company Tracking Number: LGSP3A
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense
 Product Name: Limited Benefit Surgical and Medical Expense Policy
 Project Name/Number: Limited Benefit Surgical and Medical Expense Policy/LGSP3A

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Limited Benefit Surgical and Medical Expense Policy	06/03/2009	LGSP3A - AR.pdf LGSP3A-AddSchPgs.pdf
No original date	Form	Limited Benefit Surgical and Medical Expense Policy	05/28/2009	LGSP3A - AR.pdf LGSP3A-AddSchPgs.pdf

LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE POLICY
 GUARANTEED RENEWABLE FOR YOU AND EACH COVERED FAMILY MEMBER AS STATED IN THE RENEWAL
 AGREEMENT. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS.

Liberty National Life Insurance Company
 P. O. BOX 8080, MCKINNEY, TEXAS 75070 * (972) 529-5085
 A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

30-DAY RIGHT TO EXAMINE POLICY

If YOU are not satisfied with this policy for any reason, return it to OUR Administrative Offices or to the agent within 30 days after YOU receive it. Any premium YOU paid will be refunded. The policy will be void from the beginning. It will be as if no policy had been issued.

RENEWAL AGREEMENT

YOU can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under OUR applicable table of premium rates that is in effect on the respective due dates of the premiums. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54] PART 2 Radiation Therapy Benefit up to \$ [5,000.00] PART 3 Ambulance Benefit up to \$ [200.00]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]} PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
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POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	12345678	09-01-08	10-01-08	\$100.00]

ADDITIONAL BENEFIT RIDERS

[Increasing Benefit Rider], [Critical Illness Benefit Rider], [Accident Benefit Rider], [Cancer Benefit Rider]

The Policy Schedule includes premiums for additional benefit riders, if any, unless provided to the contrary in the rider(s).

INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. For the purpose of determining benefits payable for a particular SICKNESS of a COVERED PERSON after the applicable benefit limits for that SICKNESS have been paid by the COMPANY, it shall be considered a new SICKNESS, which is then again covered under this policy, if the COVERED PERSON goes without a PHYSICIAN'S advice or treatment for that particular SICKNESS for a period of 24 consecutive months. OUR obligation to make payment under this policy for any particular SICKNESS or INJURY shall not exceed the amounts disclosed in the Benefit Schedule or described elsewhere in this policy. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a charge that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. An expense or charge is incurred on the date the care, treatment, service, or supply is provided.

PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by YOU or a covered FAMILY MEMBER during the 12 months immediately after the effective date of this policy if that loss results from a PRE-EXISTING CONDITION. In addition, any PRE-EXISTING CONDITION listed on the application is not covered for the first 12 months after the policy effective date. Conditions, illnesses, diseases, disorders, or injuries specifically excluded by rider are never covered.

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DEFINITIONS

Where used in this policy:

ACCIDENT and **ACCIDENTAL** means that which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual and unforeseen.

AMBULATORY SURGICAL CENTER means a freestanding facility, other than a PHYSICIAN'S office, where surgical and diagnostic services are provided on an ambulatory basis.

CHILD PREVENTIVE HEALTH CARE SERVICES means PHYSICIAN-delivered or PHYSICIAN-supervised services for covered dependents from birth through eighteen (18) years of age that are provided for PERIODIC PREVENTIVE CARE VISITS, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

COVERED PERSON means YOU or any covered Family Member.

DIABETES SELF-MANAGEMENT TRAINING means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Such instruction is provided in accordance with a program in compliance with the National Standards for DIABETES SELF-MANAGEMENT EDUCATION PROGRAM as developed by the American Diabetes Association.

FAMILY MEMBER means a person who is named in the application for coverage under this policy, other than the Proposed Insured, or a person who has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

HOSPITAL means a medical facility, operated pursuant to law, which: (1) is primarily and continuously engaged in providing medical and diagnostic care for the treatment of sick or injured persons on an acute care inpatient basis under the supervision of one or more licensed PHYSICIANS for which a charge is made; and (2) provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.). "HOSPITAL" does not mean a facility or special unit of a facility primarily operated as: (a) a convalescent, skilled nursing, swing bed, or other nursing facility; (b) a facility or special unit of a facility primarily affording rehabilitative care; or (c) a facility or special unit of a facility primarily affording care or treatment for the aged, or for chemical dependency, alcohol abuse, or mental or nervous disorder.

HOSPITAL STAY means one day or more of inpatient confinement within a HOSPITAL, and under the care of a PHYSICIAN, for which a charge for room and board is incurred due to an INJURY or SICKNESS.

INHERITED METABOLIC DISEASE means a disease caused by an inherited abnormality of body chemistry.

INJURY means accidental bodily INJURY sustained by a COVERED PERSON which is the direct cause independently of disease, bodily infirmity or other cause of the loss and occurs while the insurance is in force.

INTENSIVE CARE means care which is provided within a separate area or unit of a HOSPITAL that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of PHYSICIANS, nurses or other medical specialists assisting in the unit. INTENSIVE CARE does not include: step-down, isolation, telemetry, or post-intensive care units of a HOSPITAL.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a PHYSICIAN for the dietary treatment of an INHERITED METABOLIC DISEASE.

MASTECTOMY means the removal of all or part of the breast for MEDICALLY NECESSARY reasons as determined by a PHYSICIAN who is licensed as a medical doctor or doctor of osteopathy.

MEDICALLY NECESSARY means:

- 1) consistent with the symptoms or diagnosis and treatment of YOUR or a covered FAMILY MEMBER'S SICKNESS or INJURY; and
- 2) appropriate with regard to the standards of good medical practice; and
- 3) the most appropriate level of service that can be safely provided to YOU or a covered FAMILY MEMBER.

In order to determine that care is MEDICALLY NECESSARY, WE reserve the right to obtain, at Our expense, a second opinion from a PHYSICIAN who (a) is not an employee or owner of a facility or agency from which YOU or a covered FAMILY MEMBER receive care, and (b) specializes in the condition that is the subject of YOUR claim.

MENTAL ILLNESS means psychosis, neurosis or an emotional disorder.

PERIODIC PREVENTIVE CARE VISITS means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

PHYSICIAN and **DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorders, or diagnostic services, which are specifically covered under PART 7 of this policy, PHYSICIAN or DOCTOR does not include YOU or any member of YOUR household or immediate family. Primary Care Physician means a PHYSICIAN who provides basic diagnosis and treatment of common illnesses and medical conditions. A Specialist means a PHYSICIAN who provides diagnosis and treatment for a specific specialty of medicine for which he or she has received additional education, training and experience.

PRE-EXISTING CONDITION means any medical condition, illness, disease, disorder, or INJURY for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy. It also means any medical condition, illness, disease, disorder, or INJURY for which YOU or the covered FAMILY MEMBER did receive treatment or medical advice during the 12 month period immediately prior to YOUR or the covered FAMILY MEMBER'S effective date of coverage under this policy. PRE-EXISTING CONDITION will include any medical condition, illness, disease, disorder, or INJURY listed on YOUR application for YOU or a covered FAMILY MEMBER, which occurred within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy, irrespective of whether a rider has been issued. It also means a pregnancy existing at any time prior to, and which continues to exist as of, the Effective Date of YOUR or the covered FAMILY MEMBER'S coverage under this policy.

RADIATION THERAPY means the treatment of a SICKNESS by application of roentgen rays, radium, ultraviolet, and other radiations.

RELATIVE VALUE UNITS means the total unit value of the service, including all three components: PHYSICIAN work, facility practice expense, and professional liability expense, as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS).

RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) means the scale of relative values for medical and SURGICAL PROCEDURES that is maintained and updated by the Centers for Medicare and Medicaid Services with input from the AMA/Specialty Society Relative Value Scale Committee (RUC).

SICKNESS means a medical condition, illness, disease, or disorder which first manifests itself more than 30 days after the Effective Date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder. SICKNESS includes continuations and reoccurrences of the medical condition, illness, disease, or disorder, and all general conditions associated with, related to, or caused by the medical condition, illness, disease, or disorder.

SURGICAL PROCEDURE means the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, endoscopic examinations, and any one procedure designated by Current Procedural Terminology codes as surgery, except that venipuncture for the collection of blood for the purpose of performing a test shall not be considered a surgery. SURGICAL PROCEDURE shall also include all post-operative care for the 90-day period following surgery.

WE, US, OUR and **COMPANY** mean Liberty National Life Insurance Company.

YOU, YOUR, YOURS and **INSURED** mean the COVERED PERSON whose name is shown in the POLICY SCHEDULE as the Insured.

PART 1

SURGICAL PROCEDURE BENEFITS

1. SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN performing a MEDICALLY NECESSARY SURGICAL PROCEDURE on YOU or a covered FAMILY MEMBER. Such SURGICAL PROCEDURE and expenses incurred must be the result of an INJURY or SICKNESS. The benefit will be equal to the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE, but, in no event will the benefit payable be more than the lesser of either: (a) an amount equal to the Surgery Conversion Factor stated in the Benefit Schedule times the RELATIVE VALUE UNITS for that procedure as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) last published and effective before the date of the SURGICAL PROCEDURE; or (b) the Surgeon Benefit Limit amount stated in the Benefit Schedule. If the SURGICAL PROCEDURE is not contained in the RBRVS, the benefit payable will be the lesser of: (a) the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE; (b) the amount that would be payable for the most comparable SURGICAL PROCEDURE in severity and gravity; or (c) the Surgeon Benefit Limit amount stated in the Benefit Schedule. In the event that the RBRVS is discontinued, WE shall thereafter have the right to continue to use the RELATIVE VALUE UNITS contained in the last published RBRVS or, at OUR option and upon reasonable written notice to YOU, WE may designate an alternative, generally accepted, method to be used for determining relative values from the date specified in OUR notice.

WE will not pay a benefit for more than one SURGICAL PROCEDURE (the largest applicable) under this PART 1 for all SURGICAL PROCEDURES performed as a result of any one INJURY or SICKNESS.

For any one INJURY or SICKNESS, WE will pay the greater of either: (a) the Surgeon Benefit provided in this PART 1; or (b) the total of all Doctor Office Visit Benefits under PART 4 which would otherwise be payable.

2. ASSISTANT SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY assistance to the primary PHYSICIAN during a Surgical Procedure for which a Surgeon Benefit is payable under this PART 1. Such surgical assistance and expenses incurred must be the result of an INJURY or SICKNESS. The benefits will not exceed 20% of the amount payable for the Surgeon Benefit.

3. ADMINISTRATION OF ANESTHETIC BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY administration of anesthetic to YOU or a covered FAMILY MEMBER during a SURGICAL PROCEDURE for which a Surgeon Benefit is payable under this PART 1. Such anesthetic administration and expenses incurred must be the result of an INJURY or SICKNESS. The administration of anesthetic must be by a PHYSICIAN or a legally qualified anesthetist. The benefits will not exceed 25% of the amount payable for the Surgeon Benefit. WE will not pay any benefit for the administration of anesthetic by the primary PHYSICIAN or the assistant surgeon.

PART 2 RADIATION THERAPY BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY RADIATION THERAPY provided to or for YOU or a covered FAMILY MEMBER at a HOSPITAL or PHYSICIAN'S office. Such RADIATION THERAPY and expenses incurred must be the result of an INJURY or SICKNESS. WE will not pay benefits in excess of the Radiation Therapy Benefit stated in the Benefit Schedule for all such expense incurred because of any one INJURY or SICKNESS. The benefit under this PART 2 will be calculated and paid based on a single diagnosed SICKNESS, may be present or has or have been treated.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 2, only one benefit, the largest, will be payable for such expense.

PART 3 AMBULANCE BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY ambulance service for YOU or a covered FAMILY MEMBER. Such ambulance service and expenses incurred must be the result of an INJURY or SICKNESS. The ambulance service must be to or from a HOSPITAL. WE will not pay more than the Ambulance Benefit stated in the Benefit Schedule for any one INJURY or SICKNESS, regardless of the frequency that ambulance service is required because of that INJURY or SICKNESS. Only one benefit will be payable for any one trip.

{PART 4 DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER for outpatient care, treatment and services, by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one Doctor Office Visit Benefit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER and regardless of the number of visits during the day;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.}

PART 5

OUTPATIENT EXPENSE BENEFIT

WE will pay a benefit at the rate of 80% of expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Outpatient Deductible Amount stated in the Benefit Schedule, for MEDICALLY NECESSARY outpatient care, treatment, and services provided to or for YOU or a covered FAMILY MEMBER. Such outpatient care, treatment, and services and expenses incurred must be the result of an INJURY or SICKNESS. outpatient care, treatment, and services include:

1. Outpatient Hospital expense;
2. Diagnostic imaging performed at other duly licensed locations; and
3. Laboratory tests performed at other duly licensed locations, including pathology tests.

WE will not pay in excess of the Outpatient Expense Benefit stated in the Benefit Schedule for expenses incurred for outpatient care, treatment, and services resulting from any one INJURY or SICKNESS.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 5, only one benefit, the largest, will be payable for such expense.

PART 6

REFUND OF PREMIUMS FOR LOSS OF LIFE FROM ACCIDENTAL INJURY

WE will refund to YOUR estate the premiums paid for YOUR individual coverage under this policy if YOU die due to an INJURY while YOUR coverage is in force or effect. WE will refund to YOU the premiums paid under this policy for the coverage of a covered FAMILY MEMBER if that member dies due to an INJURY while his or her coverage is in force or effect.

To be entitled to said refund of premium, the death must occur while this policy is in force and within 180 days of the INJURY causing death.

PART 7

OTHER BENEFITS

On the condition that a benefit for expenses incurred for the following care, treatment, services, and supplies is not elsewhere provided in this policy, WE will pay benefits for expenses incurred for the following care, treatment, services, and supplies provided to a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 7 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 7 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, DEDUCTIBLES, CO-PAYS, CO-INSURANCE, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 7. A benefit payable under this PART 7 shall not duplicate any benefit or benefits payable under any other PART or PARTS of this policy. The total benefit payable for care, treatment, services, and supplies covered under this PART 7 of the policy, together with benefits paid under any other policy or policies issued by US to YOU or a covered FAMILY MEMBER, will never exceed the total expense incurred by YOU or the covered FAMILY MEMBER for such care, treatment, services, and supplies.

1. MATERNITY BENEFITS, MINIMUM HOSPITAL STAYS

As described in PART 8(1), this policy does not provide benefits for normal pregnancy. However, for a HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will provide a benefit for expenses incurred due to a distinct complication of pregnancy by any COVERED PERSON for a HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor.

2. PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY BENEFIT

WE will provide a benefit for the following expenses incurred by YOU or a covered FAMILY MEMBER for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

- 1) Reconstruction of the breast on which MEDICALLY NECESSARY MASTECTOMY has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) Prosthesis and physical complications from all stages of MASTECTOMY, including lymphedemas.

To be covered, breast reconstructive surgery must be in the manner chosen by the affected COVERED PERSON'S treating PHYSICIAN, who is a licensed medical doctor or doctor of osteopathy, consistent with prevailing medical standards, and in consultation with the affected COVERED PERSON.

A benefit for prosthetic devices and breast reconstructive surgery covered under this subpart of PART 7 will be paid as follows:

- a. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy because such care is not being provided in relation to a SICKNESS, or because maximum policy benefits have been paid previously for the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY, WE will consider that COVERED PERSON'S prosthetic devices and breast reconstructive surgery as though they were for a new Sickness (separate from the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY) under this policy.
- b. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$500 for prosthetic devices and breast reconstructive surgery for any one COVERED PERSON.

3. CHILD PREVENTIVE HEALTH CARE SERVICES BENEFIT

WE will provide a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for a periodic review related to CHILD HEALTH SUPERVISION SERVICES for a COVERED PERSON when that COVERED PERSON attains the following ages: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. CHILD HEALTH SUPERVISION SERVICES shall be limited to services provided by or under the supervision of a single PHYSICIAN or other primary health care provider who is a licensed medical doctor or doctor of osteopathy during the course of one visit.

If the periodic visit is not otherwise covered under another PART of this policy, WE will pay a benefit under this subpart of PART 7 in accordance with the following:

- a. For the expenses incurred for the services attributable to a history, physical examination, developmental assessment anticipatory guidance, or any combination thereof, WE will make payment as if such services were for a covered PHYSICIAN'S wellness exam payable under PART 4(3). This benefit will be provided for each such periodic visit. The combined amount of payments made during any policy year for any one COVERED PERSON under 16 years of age for Doctor Office Visits payable under PART 4, as stated in the Benefit Schedule, and for periodic visits during which services attributable to a history, physical examination, developmental assessment and anticipatory guidance are provided, payable as set forth herein, shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule.
- b. For the expenses incurred for the services attributable to laboratory tests, WE will pay a sum of money equal to 80% of the incurred expenses, not to exceed a maximum benefit of \$250 for each covered periodic visit during which, laboratory tests are provided to or for any one COVERED PERSON.
- c. For the expense incurred for covered immunizations for a COVERED PERSON under this subpart of PART 7, WE will pay a sum of money equal to 100% of the incurred expense.

Benefits paid under this subpart of PART 7 shall not exceed the reimbursement levels established by the Insurance Commissioner that shall not exceed those established for the same services under the Medicaid program in the State of Arkansas. This benefit is exempt from any deductible provision, but remains subject to all co-pay and coinsurance provisions, of this policy except in regards to immunizations the benefit for which is not subject to any deductible, copayment, or coinsurance provisions of this policy.

4. DIABETES BENEFIT

WE will provide a benefit for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

The diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Any nutrition counseling must be provided by a licensed dietician.

For equipment, supplies, treatment, service, training, or any combination thereof, for diabetes covered under this subpart of PART 7, and not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge not to exceed a maximum benefit of \$1,500 during any policy year for all equipment, supplies, treatment, service, or training for diabetes provided that COVERED PERSON.

5. ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES BENEFIT

WE will provide a benefit for general anesthesia, hospital charges, or both for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

- 1) is younger than 7 years of age;
- 2) has a serious mental or physical condition; or
- 3) has significant behavioral problems.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 7.

A benefit for anesthesia or facility charges for dental care covered under this subpart of PART 7 will be paid as follows:

- a. For anesthesia or facility charges for dental care not otherwise eligible for coverage under this policy, WE will consider that COVERED PERSON'S incurred expenses for anesthesia and facility charges for dental care as though they were eligible for coverage under and PART 5 of the policy.
- b. For anesthesia or facility charges for dental care not covered under PARTS 1-5 of this policy, or brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$100 for all anesthesia and facility charges for dental care provided to any one COVERED PERSON.

6. SPEECH AND HEARING DISORDERS BENEFIT

WE will provide a benefit for the expenses incurred for MEDICALLY NECESSARY care and treatment of loss or impairment of speech or hearing, or both if treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association or both, and which fall within the scope of their license or certification. This benefit does not cover hearing aids, instruments or devices.

Benefits for speech and hearing disorders covered under this subpart of PART 7 will be paid as follows:

- a. For speech or hearing treatment or care not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered SICKNESS, WE will consider that COVERED PERSON'S speech or hearing treatment as though it was for a covered SICKNESS under PART 4. The combined amount of payments made for any one COVERED PERSON for Physician Office Visit Benefits payable under PART 4 and speech and hearing disorders benefits payable under this subpart of PART 7 shall not exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for all benefits paid during any one policy year.
- b. For speech or hearing treatment not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each visit with a professional described in this subpart for any one COVERED PERSON, and when combined with the Physician Office Visit Benefits payable under PART 4, not to exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for benefits paid during any one policy year.

7. MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT

WE will provide a benefit for the expense incurred for Medical Foods, Low Protein Modified Food Products, amino acid modified preparations and any other special dietary products and formulas for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products, amino acid modified preparations and other special dietary products and formulas are prescribed as **MEDICALLY NECESSARY** for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a **PHYSICIAN**.

For benefits for Medical Foods and Low Protein Modified Food Products covered under this subpart of PART 7 that are not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$2,400 for each Covered Person during any one policy year as provided under the Income Tax Act of 1929.

8. COLORECTAL CANCER SCREENING BENEFIT

WE will provide a benefit for the expense incurred for colorectal cancer examinations and laboratory tests for a **COVERED PERSON** who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a **PHYSICIAN** licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
 - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
 - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
 - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and
 - iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Benefits for colorectal cancer screening covered under this subpart of PART 7 will be paid as follows:

- a. For colorectal cancer screening not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered **SICKNESS**, WE will consider that **COVERED PERSON'S** colorectal cancer testing as though it was for a covered **SICKNESS** under PART 4 and PART 5 of this policy.
- b. For colorectal cancer screening not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each screening provided a **COVERED PERSON**.

9. MENTAL ILLNESS BENEFIT

WE will provide a benefit for expenses incurred for a **COVERED PERSON** for the treatment of **MENTAL ILLNESS** on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

10. TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER BENEFIT

WE will provide coverage for the treatment and care provided to or for a **COVERED PERSON** for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is **MEDICALLY NECESSARY** to treat conditions caused by a congenital or developmental deformity, disease, disorder, or **INJURY**. A temporomandibular and craniomandibular disorder shall be treated as any other **SICKNESS** under this policy, and benefits will be paid under PARTS 1-5 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.

PART 8

LIMITATIONS AND EXCLUSIONS

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, WE will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, PHYSICIAN-prescribed rest, morning SICKNESS, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of INJURY or SICKNESS (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a HOSPITAL; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by INJURY), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any inpatient or outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies for which YOU or a covered FAMILY MEMBER do not incur a charge; or
6. Any outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies that are not MEDICALLY NECESSARY for diagnosis of or for care, treatment, or services resulting from an INJURY or SICKNESS; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during an inpatient HOSPITAL STAY; or
10. Any rehabilitative care services received at a facility not meeting the definition of a HOSPITAL; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any SICKNESS medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the COVERED PERSON has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a PHYSICIAN; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any COVERED PERSON being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

POLICY PROVISIONS

ELIGIBILITY AND INSURED'S TERMINATION: YOU, as the Insured, are the beneficiary of YOUR covered FAMILY MEMBERS. Every transaction relating to this policy shall be between US and YOU.

A new family member (including husband, wife, or any children under the age of 19 at the time the policy is issued) will be covered; each new member must be named in the application. Stepchildren and legally adopted children can be included if listed in the application. Any newborn or newly adopted children of the PRIMARY INSURED will automatically be a COVERED PERSON from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children YOU have filed a petition to adopt. YOU may apply for coverage on other dependents acquired after the EFFECTIVE DATE of the policy, subject to OUR approval.

Coverage on YOUR children terminate when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on YOU due to a physical or mental handicap, or because they are a full-time student under age 23. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 21st birthday, then the child will continue to be a COVERED PERSON for as long as such disability continues. Proof of such incapacity or disability must be furnished upon OUR request, but not more often than annually.

In the event of YOUR death or other termination of YOUR coverage, the following shall successively become the Insured: (1) YOUR spouse (if YOUR spouse is a covered FAMILY MEMBER), or (2) YOUR eldest remaining covered FAMILY MEMBER.

RIGHTS OF A SPOUSE: Should YOU and YOUR spouse dissolve YOUR marriage by a valid decree of dissolution of marriage and the spouse was a covered FAMILY MEMBER, the spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, the spouse must make application to the COMPANY within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting or probationary period is required, except to the extent that such period has not been met under the prior policy.

PREMIUM PAYMENT: This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time of the place where YOU reside, and remains in effect until the same hour on the date that the initial term expires.

The effective date of this policy, the first premium, and the date the initial term expires are stated in the POLICY SCHEDULE. All premiums, except the first premium, shall be due and payable at OUR Administrative Offices.

ENTIRE CONTRACT; CHANGES: This policy, with the application and attached papers, is the entire contract between YOU and US. No change in this policy shall be effective until approved by an officer of US. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the effective date, only fraudulent misstatements in the application may be used to void this policy or deny any claim for loss incurred after the 2-year period.

After 2 years from the date of an endorsement adding a FAMILY MEMBER, other than a newborn or newly adopted child, only fraudulent misstatements in the application may be used to void the endorsement or deny any claim for loss incurred after the 2 year period.

GRACE PERIOD: This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, this policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by US without requiring an application for reinstatement will reinstate this policy.

If WE require an application, this policy will be reinstated when WE approve the application, or on the 45th day after WE receive it, unless WE have previously written to YOU of its disapproval.

The reinstated policy will cover only loss that results from an INJURY sustained after the date of reinstatement or a SICKNESS that manifests itself more than 10 days after such date. In all other respects, YOUR rights and OUR rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given to US within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to US at OUR Administrative Offices in McKinney, Texas or to OUR agent.

Notice should include YOUR name and YOUR policy number.

CLAIM FORMS: When WE receive the Notice of Claim, WE will send YOU forms for filing proof of loss. If these forms are not given to YOU within 15 days, YOU may meet the proof of loss requirements by giving US a written statement of the nature and extent of the loss within the time limit stated in the PROOFS OF LOSS Provision set forth below.

PROOFS OF LOSS: YOU must give US written proof of loss to OUR satisfaction within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, WE will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless YOU were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: After receiving proper written proof of loss satisfactory to US, WE will pay to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person rendering services covered by this policy, all benefits then due for such loss.

PAYMENT OF CLAIMS: Benefits will be paid, after receiving a claim form and proper written proof of loss satisfactory to US, to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person providing care, treatment, services, or supplies covered by this policy. Any benefit unpaid at death may be paid to YOUR named beneficiary or, at OUR option, to YOUR estate. If benefits are payable to YOUR estate, WE can pay benefits up to \$3,000 to someone related to YOU by blood or marriage whom WE consider to be entitled to the benefits. WE will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS: WE, at OUR expense, have the right to have YOU or a covered FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

NONDUPLICATION OF COVERAGE: The benefits payable under this policy shall be excess over benefits paid or payable or required to be provided:

1. under any workers' compensation, occupational disease, employers' liability or similar law;
2. under any motor vehicle no-fault plan or coverage or similar law; and
3. under any national, state, or other governmental plan not limited to governmental employees or their families, such as Medicare or Medicaid.

REFUND OF UNEARNED PREMIUMS ON DEATH: Upon the death of a FAMILY MEMBER insured under this policy, WE will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after WE receive proof of death.

SUBROGATION; REIMBURSEMENT: YOU agree that, to the extent of the benefits paid under this policy, WE shall be subrogated to all YOUR rights to damages or recovery for any INJURY or SICKNESS, or any care, treatment, services, or supplies provided, for which a third party or parties, or their insurance carrier(s), are or may be liable or responsible. YOU agree to repay US first out of any monies YOU receive or recover by settlement, judgment or otherwise, regardless of whether YOU are fully compensated for YOUR losses and damages. In the event that WE retain OUR own attorney to represent OUR subrogation interest, WE will not be responsible for paying a portion of YOUR attorney fees or costs.

YOU assign to US YOUR claims and rights against all liable or responsible third party or parties and their insurance carrier(s) to the extent of OUR payments, and shall do nothing after the loss to prejudice OUR subrogation rights. Entering into a settlement or compromise arrangement with a third party or parties, or their insurance carrier(s), without OUR prior written consent, shall be deemed to prejudice OUR subrogation rights. YOU shall promptly advise US in writing whenever a claim or demand against a third party or parties, or their insurance carrier(s), is made, and shall further provide to US such additional information and execute and deliver such instruments or papers as are reasonably requested by US to secure OUR subrogation rights. YOU agree to fully cooperate in protecting OUR subrogation rights against the liable or responsible third party or parties, and their insurance carrier(s).

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of the claim is required to be given.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which YOU reside on that date, is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under this policy shall be binding upon US unless the original written assignment (or a copy thereof) is on file at OUR Administrative Offices. At OUR option, WE may waive this requirement. WE do not assume any responsibility for the validity of any assignment.

This policy is signed for US by OUR President and Secretary.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Visit Copay (Primary Care Physician) . \$ [35.00]} {Doctor Visit Copay (Specialist). \$ [35.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4

DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a Surgical Procedure, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not to exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care PHYSICIAN or Specialist.] }

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit up to \$ [200.00]} {Wellness Exam Benefit up to \$ [200.00]} {Doctor Visit Copay (Primary Care Physician) .\$ [35.00]} {Doctor Visit Copay (Specialist). \$ [50.00]} {Doctor Office Visit Yearly Maximum. [6] Visits}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit 80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4 DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a Hospital (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require Surgical Procedure, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule, Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit as the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, BUT, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total number of DOCTOR visits for which benefits are payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care Physician or Specialist.] }

Doctor Visit Copay w/Visit Max.

LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE POLICY
 GUARANTEED RENEWABLE FOR YOU AND EACH COVERED FAMILY MEMBER AS STATED IN THE RENEWAL
 AGREEMENT. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS.

Liberty National Life Insurance Company
 P. O. BOX 8080, MCKINNEY, TEXAS 75070 * (972) 529-5085
 A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

30-DAY RIGHT TO EXAMINE POLICY

If YOU are not satisfied with this policy for any reason, return it to OUR Administrative Offices or to the agent within 30 days after YOU receive it. Any premium YOU paid will be refunded. The policy will be void from the beginning. It will be as if no policy had been issued.

RENEWAL AGREEMENT

YOU can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under OUR applicable table of premium rates that is in effect on the respective due dates of the premiums. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54] PART 2 Radiation Therapy Benefit up to \$ [5,000.00] PART 3 Ambulance Benefit up to \$ [200.00]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]} PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
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POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	12345678	09-01-08	10-01-08	\$100.00]

ADDITIONAL BENEFIT RIDERS

[Increasing Benefit Rider], [Critical Illness Benefit Rider], [Accident Benefit Rider], [Cancer Benefit Rider]

The Policy Schedule includes premiums for additional benefit riders, if any, unless provided to the contrary in the rider(s).

INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. For the purpose of determining benefits payable for a particular SICKNESS of a COVERED PERSON after the applicable benefit limits for that SICKNESS have been paid by the COMPANY, it shall be considered a new SICKNESS, which is then again covered under this policy, if the COVERED PERSON goes without a PHYSICIAN'S advice or treatment for that particular SICKNESS for a period of 24 consecutive months. OUR obligation to make payment under this policy for any particular SICKNESS or INJURY shall not exceed the amounts disclosed in the Benefit Schedule or described elsewhere in this policy. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a charge that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. An expense or charge is incurred on the date the care, treatment, service, or supply is provided.

PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by YOU or a covered FAMILY MEMBER during the 12 months immediately after the effective date of this policy if that loss results from a PRE-EXISTING CONDITION. In addition, any PRE-EXISTING CONDITION listed on the application is not covered for the first 12 months after the policy effective date. Conditions, illnesses, diseases, disorders, or injuries specifically excluded by rider are never covered.

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DEFINITIONS

Where used in this policy:

ACCIDENT and **ACCIDENTAL** means that which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual and unforeseen.

AMBULATORY SURGICAL CENTER means a freestanding facility, other than a PHYSICIAN'S office, where surgical and diagnostic services are provided on an ambulatory basis.

CHILD PREVENTIVE HEALTH CARE SERVICES means PHYSICIAN-delivered or PHYSICIAN-supervised services for covered dependents from birth through eighteen (18) years of age that are provided for PERIODIC PREVENTIVE CARE VISITS, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

COVERED PERSON means YOU or any covered Family Member.

DIABETES SELF-MANAGEMENT TRAINING means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Such instruction is provided in accordance with a program in compliance with the National Standards for DIABETES SELF-MANAGEMENT EDUCATION PROGRAM as developed by the American Diabetes Association.

FAMILY MEMBER means a person who is named in the application for coverage under this policy, other than the Proposed Insured, or a person who has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

HOSPITAL means a medical facility, operated pursuant to law, which: (1) is primarily and continuously engaged in providing medical and diagnostic care for the treatment of sick or injured persons on an acute care inpatient basis under the supervision of one or more licensed PHYSICIANS for which a charge is made; and (2) provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.). "HOSPITAL" does not mean a facility or special unit of a facility primarily operated as: (a) a convalescent, skilled nursing, swing bed, or other nursing facility; (b) a facility or special unit of a facility primarily affording rehabilitative care; or (c) a facility or special unit of a facility primarily affording care or treatment for the aged, or for chemical dependency, alcohol abuse, or mental or nervous disorder.

HOSPITAL STAY means one day or more of inpatient confinement within a HOSPITAL, and under the care of a PHYSICIAN, for which a charge for room and board is incurred due to an INJURY or SICKNESS.

INHERITED METABOLIC DISEASE means a disease caused by an inherited abnormality of body chemistry.

INJURY means accidental bodily INJURY sustained by a COVERED PERSON which is the direct cause independently of disease, bodily infirmity or other cause of the loss and occurs while the insurance is in force.

INTENSIVE CARE means care which is provided within a separate area or unit of a HOSPITAL that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of PHYSICIANS, nurses or other medical specialists assisting in the unit. INTENSIVE CARE does not include: step-down, isolation, telemetry, or post-intensive care units of a HOSPITAL.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a PHYSICIAN for the dietary treatment of an INHERITED METABOLIC DISEASE.

MASTECTOMY means the removal of all or part of the breast for MEDICALLY NECESSARY reasons as determined by a PHYSICIAN who is licensed as a medical doctor or doctor of osteopathy.

MEDICALLY NECESSARY means:

- 1) consistent with the symptoms or diagnosis and treatment of YOUR or a covered FAMILY MEMBER'S SICKNESS or INJURY; and
- 2) appropriate with regard to the standards of good medical practice; and
- 3) the most appropriate level of service that can be safely provided to YOU or a covered FAMILY MEMBER.

In order to determine that care is MEDICALLY NECESSARY, WE reserve the right to obtain, at Our expense, a second opinion from a PHYSICIAN who (a) is not an employee or owner of a facility or agency from which YOU or a covered FAMILY MEMBER receive care, and (b) specializes in the condition that is the subject of YOUR claim.

MENTAL ILLNESS means psychosis, neurosis or an emotional disorder.

PERIODIC PREVENTIVE CARE VISITS means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

PHYSICIAN and **DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorders, or diagnostic services, which are specifically covered under PART 7 of this policy, PHYSICIAN or DOCTOR does not include YOU or any member of YOUR household or immediate family. Primary Care Physician means a PHYSICIAN who provides basic diagnosis and treatment of common illnesses and medical conditions. A Specialist means a PHYSICIAN who provides diagnosis and treatment for a specific specialty of medicine for which he or she has received additional education, training and experience.

PRE-EXISTING CONDITION means any medical condition, illness, disease, disorder, or INJURY for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy. It also means any medical condition, illness, disease, disorder, or INJURY for which YOU or the covered FAMILY MEMBER did receive treatment or medical advice during the 12 month period immediately prior to YOUR or the covered FAMILY MEMBER'S effective date of coverage under this policy. PRE-EXISTING CONDITION will include any medical condition, illness, disease, disorder, or INJURY listed on YOUR application for YOU or a covered FAMILY MEMBER, which occurred within the 12 month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy, irrespective of whether a rider has been issued. It also means a pregnancy existing at any time prior to, and which continues to exist as of, the Effective Date of YOUR or the covered FAMILY MEMBER'S coverage under this policy.

RADIATION THERAPY means the treatment of a SICKNESS by application of roentgen rays, radium, ultraviolet, and other radiations.

RELATIVE VALUE UNITS means the total unit value of the service, including all three components: PHYSICIAN work, facility practice expense, and professional liability expense, as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS).

RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) means the scale of relative values for medical and SURGICAL PROCEDURES that is maintained and updated by the Centers for Medicare and Medicaid Services with input from the AMA/Specialty Society Relative Value Scale Committee (RUC).

SICKNESS means a medical condition, illness, disease, or disorder which first manifests itself more than 30 days after the Effective Date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder. SICKNESS includes continuations and reoccurrences of the medical condition, illness, disease, or disorder, and all general conditions associated with, related to, or caused by the medical condition, illness, disease, or disorder.

SURGICAL PROCEDURE means the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, endoscopic examinations, and any one procedure designated by Current Procedural Terminology codes as surgery, except that venipuncture for the collection of blood for the purpose of performing a test shall not be considered a surgery. SURGICAL PROCEDURE shall also include all post-operative care for the 90-day period following surgery.

WE, US, OUR and **COMPANY** mean Liberty National Life Insurance Company.

YOU, YOUR, YOURS and **INSURED** mean the COVERED PERSON whose name is shown in the POLICY SCHEDULE as the Insured.

PART 1

SURGICAL PROCEDURE BENEFITS

1. SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN performing a MEDICALLY NECESSARY SURGICAL PROCEDURE on YOU or a covered FAMILY MEMBER. Such SURGICAL PROCEDURE and expenses incurred must be the result of an INJURY or SICKNESS. The benefit will be equal to the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE, but, in no event will the benefit payable be more than the lesser of either: (a) an amount equal to the Surgery Conversion Factor stated in the Benefit Schedule times the RELATIVE VALUE UNITS for that procedure as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) last published and effective before the date of the SURGICAL PROCEDURE; or (b) the Surgeon Benefit Limit amount stated in the Benefit Schedule. If the SURGICAL PROCEDURE is not contained in the RBRVS, the benefit payable will be the lesser of: (a) the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE; (b) the amount that would be payable for the most comparable SURGICAL PROCEDURE in severity and gravity; or (c) the Surgeon Benefit Limit amount stated in the Benefit Schedule. In the event that the RBRVS is discontinued, WE shall thereafter have the right to continue to use the RELATIVE VALUE UNITS contained in the last published RBRVS or, at OUR option and upon reasonable written notice to YOU, WE may designate an alternative, generally accepted, method to be used for determining relative values from the date specified in OUR notice.

WE will not pay a benefit for more than one SURGICAL PROCEDURE (the largest applicable) under this PART 1 for all SURGICAL PROCEDURES performed as a result of any one INJURY or SICKNESS.

For any one INJURY or SICKNESS, WE will pay the greater of either: (a) the Surgeon Benefit provided in this PART 1; or (b) the total of all Doctor Office Visit Benefits under PART 4 which would otherwise be payable.

2. ASSISTANT SURGEON BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY assistance to the primary PHYSICIAN during a Surgical Procedure for which a Surgeon Benefit is payable under this PART 1. Such surgical assistance and expenses incurred must be the result of an INJURY or SICKNESS. The benefits will not exceed 20% of the amount payable for the Surgeon Benefit.

3. ADMINISTRATION OF ANESTHETIC BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY administration of anesthetic to YOU or a covered FAMILY MEMBER during a SURGICAL PROCEDURE for which a Surgeon Benefit is payable under this PART 1. Such anesthetic administration and expenses incurred must be the result of an INJURY or SICKNESS. The administration of anesthetic must be by a PHYSICIAN or a legally qualified anesthetist. The benefits will not exceed 25% of the amount payable for the Surgeon Benefit. WE will not pay any benefit for the administration of anesthetic by the primary PHYSICIAN or the assistant surgeon.

PART 2 RADIATION THERAPY BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY RADIATION THERAPY provided to or for YOU or a covered FAMILY MEMBER at a HOSPITAL or PHYSICIAN'S office. Such RADIATION THERAPY and expenses incurred must be the result of an INJURY or SICKNESS. WE will not pay benefits in excess of the Radiation Therapy Benefit stated in the Benefit Schedule for all such expense incurred because of any one INJURY or SICKNESS. The benefit under this PART 2 will be calculated and paid based on a single diagnosed SICKNESS, may be present or has or have been treated.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 2, only one benefit, the largest, will be payable for such expense.

PART 3 AMBULANCE BENEFIT

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY ambulance service for YOU or a covered FAMILY MEMBER. Such ambulance service and expenses incurred must be the result of an INJURY or SICKNESS. The ambulance service must be to or from a HOSPITAL. WE will not pay more than the Ambulance Benefit stated in the Benefit Schedule for any one INJURY or SICKNESS, regardless of the frequency that ambulance service is required because of that INJURY or SICKNESS. Only one benefit will be payable for any one trip.

{PART 4 DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER for outpatient care, treatment and services, by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one Doctor Office Visit Benefit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER and regardless of the number of visits during the day;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 80% of the fee charged by the DOCTOR, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.}

PART 5

OUTPATIENT EXPENSE BENEFIT

WE will pay a benefit at the rate of 80% of expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Outpatient Deductible Amount stated in the Benefit Schedule, for MEDICALLY NECESSARY outpatient care, treatment, and services provided to or for YOU or a covered FAMILY MEMBER. Such outpatient care, treatment, and services and expenses incurred must be the result of an INJURY or SICKNESS. outpatient care, treatment, and services include:

1. Outpatient Hospital expense;
2. Diagnostic imaging performed at other duly licensed locations; and
3. Laboratory tests performed at other duly licensed locations, including pathology tests.

WE will not pay in excess of the Outpatient Expense Benefit stated in the Benefit Schedule for expenses incurred for outpatient care, treatment, and services resulting from any one INJURY or SICKNESS.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 5, only one benefit, the largest, will be payable for such expense.

PART 6

REFUND OF PREMIUMS FOR LOSS OF LIFE FROM ACCIDENTAL INJURY

WE will refund to YOUR estate the premiums paid for YOUR individual coverage under this policy if YOU die due to an INJURY while YOUR coverage is in force or effect. WE will refund to YOU the premiums paid under this policy for the coverage of a covered FAMILY MEMBER if that member dies due to an INJURY while his or her coverage is in force or effect.

To be entitled to said refund of premium, the death must occur while this policy is in force and within 180 days of the INJURY causing death.

PART 7

OTHER BENEFITS

On the condition that a benefit for expenses incurred for the following care, treatment, services, and supplies is not elsewhere provided in this policy, WE will pay benefits for expenses incurred for the following care, treatment, services, and supplies provided to a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 7 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 7 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, DEDUCTIBLES, CO-PAYS, CO-INSURANCE, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 7. A benefit payable under this PART 7 shall not duplicate any benefit or benefits payable under any other PART or PARTS of this policy. The total benefit payable for care, treatment, services, and supplies covered under this PART 7 of the policy, together with benefits paid under any other policy or policies issued by US to YOU or a covered FAMILY MEMBER, will never exceed the total expense incurred by YOU or the covered FAMILY MEMBER for such care, treatment, services, and supplies.

1. MATERNITY BENEFITS, MINIMUM HOSPITAL STAYS

As described in PART 8(1), this policy does not provide benefits for normal pregnancy. However, for a HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will provide a benefit for expenses incurred due to a distinct complication of pregnancy by any COVERED PERSON for a HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor.

2. PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY BENEFIT

WE will provide a benefit for the following expenses incurred by YOU or a covered FAMILY MEMBER for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

- 1) Reconstruction of the breast on which MEDICALLY NECESSARY MASTECTOMY has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) Prosthesis and physical complications from all stages of MASTECTOMY, including lymphedemas.

To be covered, breast reconstructive surgery must be in the manner chosen by the affected COVERED PERSON'S treating PHYSICIAN, who is a licensed medical doctor or doctor of osteopathy, consistent with prevailing medical standards, and in consultation with the affected COVERED PERSON.

A benefit for prosthetic devices and breast reconstructive surgery covered under this subpart of PART 7 will be paid as follows:

- a. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy because such care is not being provided in relation to a SICKNESS, or because maximum policy benefits have been paid previously for the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY, WE will consider that COVERED PERSON'S prosthetic devices and breast reconstructive surgery as though they were for a new Sickness (separate from the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY) under this policy.
- b. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$500 for prosthetic devices and breast reconstructive surgery for any one COVERED PERSON.

3. CHILD PREVENTIVE HEALTH CARE SERVICES BENEFIT

WE will provide a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for a periodic review related to CHILD HEALTH SUPERVISION SERVICES for a COVERED PERSON when that COVERED PERSON attains the following ages: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. CHILD HEALTH SUPERVISION SERVICES shall be limited to services provided by or under the supervision of a single PHYSICIAN or other primary health care provider who is a licensed medical doctor or doctor of osteopathy during the course of one visit.

If the periodic visit is not otherwise covered under another PART of this policy, WE will pay a benefit under this subpart of PART 7 in accordance with the following:

- a. For the expenses incurred for the services attributable to a history, physical examination, developmental assessment anticipatory guidance, or any combination thereof, WE will make payment as if such services were for a covered PHYSICIAN'S wellness exam payable under PART 4(3). This benefit will be provided for each such periodic visit. The combined amount of payments made during any policy year for any one COVERED PERSON under 16 years of age for Doctor Office Visits payable under PART 4, as stated in the Benefit Schedule, and for periodic visits during which services attributable to a history, physical examination, developmental assessment and anticipatory guidance are provided, payable as set forth herein, shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule.
- b. For the expenses incurred for the services attributable to laboratory tests, WE will pay a sum of money equal to 80% of the incurred expenses, not to exceed a maximum benefit of \$250 for each covered periodic visit during which, laboratory tests are provided to or for any one COVERED PERSON.
- c. For the expense incurred for covered immunizations for a COVERED PERSON under this subpart of PART 7, WE will pay a sum of money equal to 100% of the incurred expense.

Benefits paid under this subpart of PART 7 shall not exceed the reimbursement levels established by the Insurance Commissioner that shall not exceed those established for the same services under the Medicaid program in the State of Arkansas. This benefit is exempt from any deductible provision, but remains subject to all co-pay and coinsurance provisions, of this policy except in regards to immunizations the benefit for which is not subject to any deductible, copayment, or coinsurance provisions of this policy.

4. DIABETES BENEFIT

WE will provide a benefit for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

The diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Any nutrition counseling must be provided by a licensed dietician.

For equipment, supplies, treatment, service, training, or any combination thereof, for diabetes covered under this subpart of PART 7, and not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge not to exceed a maximum benefit of \$1,500 during any policy year for all equipment, supplies, treatment, service, or training for diabetes provided that COVERED PERSON.

5. ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES BENEFIT

WE will provide a benefit for general anesthesia, hospital charges, or both for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

- 1) is younger than 7 years of age;
- 2) has a serious mental or physical condition; or
- 3) has significant behavioral problems.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 7.

A benefit for anesthesia or facility charges for dental care covered under this subpart of PART 7 will be paid as follows:

- a. For anesthesia or facility charges for dental care not otherwise eligible for coverage under this policy, WE will consider that COVERED PERSON'S incurred expenses for anesthesia and facility charges for dental care as though they were eligible for coverage under and PART 5 of the policy.
- b. For anesthesia or facility charges for dental care not covered under PARTS 1-5 of this policy, or brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$100 for all anesthesia and facility charges for dental care provided to any one COVERED PERSON.

6. SPEECH AND HEARING DISORDERS BENEFIT

WE will provide a benefit for the expenses incurred for MEDICALLY NECESSARY care and treatment of loss or impairment of speech or hearing, or both if treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association or both, and which fall within the scope of their license or certification. This benefit does not cover hearing aids, instruments or devices.

Benefits for speech and hearing disorders covered under this subpart of PART 7 will be paid as follows:

- a. For speech or hearing treatment or care not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered SICKNESS, WE will consider that COVERED PERSON'S speech or hearing treatment as though it was for a covered SICKNESS under PART 4. The combined amount of payments made for any one COVERED PERSON for Physician Office Visit Benefits payable under PART 4 and speech and hearing disorders benefits payable under this subpart of PART 7 shall not exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for all benefits paid during any one policy year.
- b. For speech or hearing treatment not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each visit with a professional described in this subpart for any one COVERED PERSON, and when combined with the Physician Office Visit Benefits payable under PART 4, not to exceed the Physician Office Visit Yearly Maximum shown on the Benefit Schedule for benefits paid during any one policy year.

7. MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT

WE will provide a benefit for the expense incurred for Medical Foods, Low Protein Modified Food Products, amino acid modified preparations and any other special dietary products and formulas for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products, amino acid modified preparations and other special dietary products and formulas are prescribed as **MEDICALLY NECESSARY** for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a **PHYSICIAN**.

For benefits for Medical Foods and Low Protein Modified Food Products covered under this subpart of PART 7 that are not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$2,400 for each Covered Person during any one policy year as provided under the Income Tax Act of 1929.

8. COLORECTAL CANCER SCREENING BENEFIT

WE will provide a benefit for the expense incurred for colorectal cancer examinations and laboratory tests for a **COVERED PERSON** who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a **PHYSICIAN** licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
 - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
 - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
 - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and
 - iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Benefits for colorectal cancer screening covered under this subpart of PART 7 will be paid as follows:

- a. For colorectal cancer screening not covered under PARTS 1-5 of this policy because such treatment or service is not being provided in relation to a covered **SICKNESS**, WE will consider that **COVERED PERSON'S** colorectal cancer testing as though it was for a covered **SICKNESS** under PART 4 and PART 5 of this policy.
- b. For colorectal cancer screening not covered under PARTS 1-5 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each screening provided a **COVERED PERSON**.

9. MENTAL ILLNESS BENEFIT

WE will provide a benefit for expenses incurred for a **COVERED PERSON** for the treatment of **MENTAL ILLNESS** on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

10. TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER BENEFIT

WE will provide coverage for the treatment and care provided to or for a **COVERED PERSON** for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is **MEDICALLY NECESSARY** to treat conditions caused by a congenital or developmental deformity, disease, disorder, or **INJURY**. A temporomandibular and craniomandibular disorder shall be treated as any other **SICKNESS** under this policy, and benefits will be paid under PARTS 1-5 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.

PART 8

LIMITATIONS AND EXCLUSIONS

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, WE will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, PHYSICIAN-prescribed rest, morning SICKNESS, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of INJURY or SICKNESS (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a HOSPITAL; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by INJURY), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any inpatient or outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies for which YOU or a covered FAMILY MEMBER do not incur a charge; or
6. Any outpatient HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies that are not MEDICALLY NECESSARY for diagnosis of or for care, treatment, or services resulting from an INJURY or SICKNESS; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during an inpatient HOSPITAL STAY; or
10. Any rehabilitative care services received at a facility not meeting the definition of a HOSPITAL; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any SICKNESS medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the COVERED PERSON has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a PHYSICIAN; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any COVERED PERSON being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

POLICY PROVISIONS

ELIGIBILITY AND INSURED'S TERMINATION: YOU, as the Insured, are the beneficiary of YOUR covered FAMILY MEMBERS. Every transaction relating to this policy shall be between US and YOU.

A new family member (including husband, wife, or any children under the age of 19 at the time the policy is issued) will be covered; each new member must be named in the application. Stepchildren and legally adopted children can be included if listed in the application. Any newborn or newly adopted children of the PRIMARY INSURED will automatically be a COVERED PERSON from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children YOU have filed a petition to adopt. YOU may apply for coverage on other dependents acquired after the EFFECTIVE DATE of the policy, subject to OUR approval.

Coverage on YOUR children terminate when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on YOU due to a physical or mental handicap, or because they are a full-time student under age 23. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 21st birthday, then the child will continue to be a COVERED PERSON for as long as such disability continues. Proof of such incapacity or disability must be furnished upon OUR request, but not more often than annually.

In the event of YOUR death or other termination of YOUR coverage, the following shall successively become the Insured: (1) YOUR spouse (if YOUR spouse is a covered FAMILY MEMBER), or (2) YOUR eldest remaining covered FAMILY MEMBER.

RIGHTS OF A SPOUSE: Should YOU and YOUR spouse dissolve YOUR marriage by a valid decree of dissolution of marriage and the spouse was a covered FAMILY MEMBER, the spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, the spouse must make application to the COMPANY within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting or probationary period is required, except to the extent that such period has not been met under the prior policy.

PREMIUM PAYMENT: This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time of the place where YOU reside, and remains in effect until the same hour on the date that the initial term expires.

The effective date of this policy, the first premium, and the date the initial term expires are stated in the POLICY SCHEDULE. All premiums, except the first premium, shall be due and payable at OUR Administrative Offices.

ENTIRE CONTRACT; CHANGES: This policy, with the application and attached papers, is the entire contract between YOU and US. No change in this policy shall be effective until approved by an officer of US. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the effective date, only fraudulent misstatements in the application may be used to void this policy or deny any claim for loss incurred after the 2-year period.

After 2 years from the date of an endorsement adding a FAMILY MEMBER, other than a newborn or newly adopted child, only fraudulent misstatements in the application may be used to void the endorsement or deny any claim for loss incurred after the 2 year period.

GRACE PERIOD: This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, this policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by US without requiring an application for reinstatement will reinstate this policy.

If WE require an application, this policy will be reinstated when WE approve the application, or on the 45th day after WE receive it, unless WE have previously written to YOU of its disapproval.

The reinstated policy will cover only loss that results from an INJURY sustained after the date of reinstatement or a SICKNESS that manifests itself more than 10 days after such date. In all other respects, YOUR rights and OUR rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given to US within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to US at OUR Administrative Offices in McKinney, Texas or to OUR agent.

Notice should include YOUR name and YOUR policy number.

CLAIM FORMS: When WE receive the Notice of Claim, WE will send YOU forms for filing proof of loss. If these forms are not given to YOU within 15 days, YOU may meet the proof of loss requirements by giving US a written statement of the nature and extent of the loss within the time limit stated in the PROOFS OF LOSS Provision set forth below.

PROOFS OF LOSS: YOU must give US written proof of loss to OUR satisfaction within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, WE will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless YOU were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: After receiving proper written proof of loss satisfactory to US, WE will pay to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person rendering services covered by this policy, all benefits then due for such loss.

PAYMENT OF CLAIMS: Benefits will be paid, after receiving a claim form and proper written proof of loss satisfactory to US, to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person providing care, treatment, services, or supplies covered by this policy. Any benefit unpaid at death may be paid to YOUR named beneficiary or, at OUR option, to YOUR estate. If benefits are payable to YOUR estate, WE can pay benefits up to \$3,000 to someone related to YOU by blood or marriage whom WE consider to be entitled to the benefits. WE will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS: WE, at OUR expense, have the right to have YOU or a covered FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

NONDUPLICATION OF COVERAGE: The benefits payable under this policy shall be excess over benefits paid or payable or required to be provided:

1. under any workers' compensation, occupational disease, employers' liability or similar law;
2. under any motor vehicle no-fault plan or coverage or similar law; and
3. under any national, state, or other governmental plan not limited to governmental employees or their families, such as Medicare or Medicaid.

REFUND OF UNEARNED PREMIUMS ON DEATH: Upon the death of a FAMILY MEMBER insured under this policy, WE will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after WE receive proof of death.

SUBROGATION; REIMBURSEMENT: YOU agree that, to the extent of the benefits paid under this policy, WE shall be subrogated to all YOUR rights to damages or recovery for any INJURY or SICKNESS, or any care, treatment, services, or supplies provided, for which a third party or parties, or their insurance carrier(s), are or may be liable or responsible. YOU agree to repay US first out of any monies YOU receive or recover by settlement, judgment or otherwise, regardless of whether YOU are fully compensated for YOUR losses and damages. In the event that WE retain OUR own attorney to represent OUR subrogation interest, WE will not be responsible for paying a portion of YOUR attorney fees or costs.

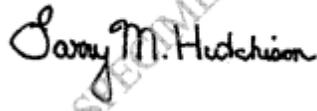
YOU assign to US YOUR claims and rights against all liable or responsible third party or parties and their insurance carrier(s) to the extent of OUR payments, and shall do nothing after the loss to prejudice OUR subrogation rights. Entering into a settlement or compromise arrangement with a third party or parties, or their insurance carrier(s), without OUR prior written consent, shall be deemed to prejudice OUR subrogation rights. YOU shall promptly advise US in writing whenever a claim or demand against a third party or parties, or their insurance carrier(s), is made, and shall further provide to US such additional information and execute and deliver such instruments or papers as are reasonably requested by US to secure OUR subrogation rights. YOU agree to fully cooperate in protecting OUR subrogation rights against the liable or responsible third party or parties, and their insurance carrier(s).

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of the claim is required to be given.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which YOU reside on that date, is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under this policy shall be binding upon US unless the original written assignment (or a copy thereof) is on file at OUR Administrative Offices. At OUR option, WE may waive this requirement. WE do not assume any responsibility for the validity of any assignment.

This policy is signed for US by OUR President and Secretary.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit80% up to \$ [25.00]} {Wellness Exam Benefit80% up to \$ [50.00]} {Doctor Visit Copay (Primary Care Physician) . \$ [35.00]} {Doctor Visit Copay (Specialist). \$ [35.00]} {Doctor Office Visit Yearly Maximum \$ [250.00]}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4

DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a HOSPITAL (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require a SURGICAL PROCEDURE, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment, and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule. Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a Surgical Procedure, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total benefits payable under this PART 4 shall not to exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care PHYSICIAN or Specialist.] }

BENEFIT SCHEDULE

PART 1 Surgeon Benefit Limit up to \$ [3,000.00] Surgery Conversion Factor [54]	PART 4 {Doctor Office Visit Benefit up to \$ [200.00]} {Wellness Exam Benefit up to \$ [200.00]} {Doctor Visit Copay (Primary Care Physician) . \$ [35.00]} {Doctor Visit Copay (Specialist). \$ [50.00]} {Doctor Office Visit Yearly Maximum. [6] Visits}
PART 2 Radiation Therapy Benefit up to \$ [5,000.00]	PART 5 Outpatient Expense Benefit 80% up to \$ [250.00] {Outpatient Deductible Amount \$ [100.00]}
PART 3 Ambulance Benefit up to \$ [200.00]	

{PART 4 DOCTOR OFFICE VISIT BENEFIT

WE will pay benefits for expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Doctor Visit Copay stated in the Benefit Schedule, for outpatient care, treatment, and services by a DOCTOR provided to or for YOU or a covered FAMILY MEMBER at the DOCTOR'S office, clinic, a Hospital (on an outpatient basis), or at place of residence according to the following:

1. For MEDICALLY NECESSARY care, treatment, and services resulting from an INJURY or SICKNESS which does not require Surgical Procedure, WE will pay a benefit at the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, but, in no event will the benefit payable for such care, treatment and services be more than the Doctor Office Visit Benefit stated in the Benefit Schedule, Only one DOCTOR'S care, treatment, and services for a single visit will be paid per day, regardless of the number of DOCTORS providing care, treatment, and services to or for YOU or the covered FAMILY MEMBER;
2. For MEDICALLY NECESSARY care, treatment, and services resulting from any one INJURY or SICKNESS which requires a SURGICAL PROCEDURE, WE will pay an amount equal to the greater of the applicable Surgeon Benefit in PART 1 or the total of the benefit in (1) above which would otherwise be payable; and
3. For a physical wellness exam in the absence of INJURY or SICKNESS, WE will pay a benefit as the rate of 100% of the fee charged by the DOCTOR, in excess of the Doctor Visit Copay, BUT, in no event will the benefit payable for any physical wellness exam performed exceed the Wellness Exam Benefit stated in the Benefit Schedule. Each COVERED PERSON will be entitled to one physical wellness exam per policy year.

The total number of DOCTOR visits for which benefits are payable under this PART 4 shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule during any policy year.

[The Doctor Visit Copay shall vary, as reflected in the Benefit Schedule, depending on whether the treating DOCTOR is a Primary Care Physician or Specialist.] }

Doctor Visit Copay w/Visit Max.